SUPPLEMENT

The Association

THE SEVENTIETH ANNUAL MEETING OF THE CANADIAN MEDICAL ASSOCIATION, HELD IN MONTREAL, QUEBEC

June 19, 20, 21, 22, 23, 1939

DURING the week of June 19, 1939, a very successful meeting of the Canadian Medical Association was held in Montreal, Quebec, when 1,085 doctors, 300 ladies, 45 young people (sons and daughters of visiting doctors) and a number of students and nurses registered, bringing the total attendance well over 1,500.

An excellent scientific program was presented, with more than 200 speakers taking part. A new undertaking this year was the Round Table Conferences held from 8.30 o'clock until 9.25 each morning for 3 days, giving an opportunity for intimate discussion in small groups.

The Scientific Exhibits were of a high order and attracted considerable attention throughout the week, as did also the continuous program of motion pictures from 9 a.m. until 6 p.m. each day.

For the ladies and young people, the week was marked by a continuous round of entertainment. Our Montreal hosts and hostesses left nothing undone that would add to the comfort and enjoyment of their guests during the week.

THE ANNUAL GENERAL MEETING OF THE ASSOCIATION

On Wednesday, June 21st, the Annual General Meeting of the Association was held in the Windsor Hotel.

At this function, Honorary Membership was conferred upon Prof. Edward Provan Cathcart, C.B.E., D.Sc., M.D., LL.D., F.R.S., Regius Professor of Physiology and Director of the Institute of Physiology, University of Glasgow, Scotland; and Dr. Allen O. Whipple, Columbia University, New York.

Senior Membership was conferred upon the following members of the Association:—

Dr Thomas Alfred Patrick, Yorkton, Sask.
Dr. W. Harvey Smith, Winnipeg, Man.
Dr. John Graham, Bolton, Ont.
Dr. Robert Dawson Rudolf, Toronto, Ont.
Dr. Joseph Edmond Dubé, Montreal.
Dr. Hubert Douglas Hamilton, Montreal.
Dr. John M. Barry, Saint John, N.B.
Dr. Charles Ashton Webster, Yarmouth, N.S.
Dr. Walter Stuart Galbraith, Lethbridge, Alta.
Dr. Ivan Glen Campbell, Vancouver, B.C.

After his installation as President of the Association Dr. Frank S. Patch gave his inaugural address.

Following the ceremony, our members and guests were transported by motor bus to the beautiful Chalet on the top of Montreal Mountain, where, after the reception by Dr. and Mrs. Patch, two or three hours were spent in dancing.

GOLF

The annual golf tournament was held on Friday afternoon, June 23rd, the winners being as follows:—

1. THE ONTARIO CUP.—Tie 69 by Dr. W. C. Gowdey, Westmount, Que., and Dr. P. L. Nelligan, Montreal. A coin was tossed and Dr. Gowdey won the cup. Dr. Nelligan was then given a runner-up prize of a silver water jug.
2. LOW GROSS.—Won by Dr. C. R. Joyce, Montreal, who was presented with a set of carvers.
3. RUNNER UP.—Won by Dr. H. D. Bayne, Sherbrooke, Que., who was given a golf bag.
4. HIDDEN HOLE.—Resulted in awards to the following: Drs. F. S. Patch, Montreal, Léon Gérin-Lajoie, Montreal, and Geo. R. Johnson, Calgary.
5. LOW NET (1st nine).—Tie between Drs. C. F. Moffatt, Montreal, and Geo. R. Johnson, Calgary. Each was awarded four balls.
6. LOW NET (2nd nine).—Won by Dr. T. I. Hoen, Montreal, who received four balls.
7. PROVINCIAL TEAM.—Won by Quebec, the four best scores being won by Drs. C. R. Joyce, W. C. Gowdey, C. F. Moffatt, all of Montreal, and H. D. Bayne, of Sherbrooke.

A number of golf balls were awarded to Dr. D. E. H. Cleveland, of Vancouver, for the golfer from the furthest point west; while Dr. W. E. Gray, of Milltown, N.B., received a similar award, being from the furthest point east.

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OUR GUESTS

Among the distinguished visitors to the meeting were Sir Arthur MacNalty, Chief Medical Officer, Ministry of Health for Great Britain, London, England; Prof. Edward Provan Cathcart, Professor of Physiology, University of Glasgow; Dr. Thomas S. Cullen of Baltimore, fraternal delegate of the American Medical Association; and Dr. Allen O. Whipple of Columbia University, New York, who gave the Lister Lecture.

MEETING OF THE GENERAL COUNCIL

The General Council met on Monday and Tuesday, June 19th and 20th, with 88 delegates present from all parts of Canada. Dr. T. H. Leggett, the Chairman, Dr. K. A. MacKenzie, the President, and Dr. F. S. Patch, President-Elect, extended words of welcome to the members.

The following is a list of those who answered the roll call:—

Drs. J. D. Adamson, Winnipeg; G. A. B. Addy, Rothsay; Harvey Agnew, Toronto; A. T. Bazin, Montreal; H. E. Britton, Moncton; C. R. Bunn, Red Deer; G. Stewart Cameron, Peterborough; M. H. V. Cameron, Toronto; F. J. H. Campbell, London; D. E. H. Cleveland, Vancouver; C. E. Corrigan, Winnipeg; J. R. Corston, Halifax; F. E. Coy, Invermere; W. A. Dakin, Regina; A. L. Danard, Owen Sound; W. J. Deadman, Hamilton; W. H. Delaney, Quebec; W. W. Francis, Montreal; J. R. Fraser, Montreal; J. U. Gariepy, Montreal; J. E. Gendreau, Montreal; Léon Gérin-Lajoie, Montreal; A. L. Gerow, Fredericton; J. C. Gillie, Fort William; Colin W. Graham, Vancouver; Duncan Graham, Toronto; H. G. Grant, Halifax; W. E. Gray, Milltown; R. I. Harris, Toronto; T. E. Holland, Winnipeg; C. J. Houston, Yorkton; O. M. Irwin, Swift Current; George R. Johnson, Calgary; Heber Jamieson, Edmonton; A. D. Kelly, Toronto; P. H. Laporte, Edmundston; G. E. Learmonth, Calgary; G. H. Lee, Prince Albert; T. H. Leggett, Ottawa; D. Sclater Lewis, Montreal; J. G. K. Lindsay, Saskatoon; W. W. Lynch, Sherbrooke; J. C. Meakins, Montreal; E. S. Mills, Montreal; Ross Mitchell, Winnipeg; E. W. Montgomery, Winnipeg; L. C. Montgomery, Montreal; J. C. Morrison, New Waterford; W. L. Muir, Halifax; J. K. Mulloy, Cardston; A. E. Macaulay, Saint John; C. W. MacCharles, Winnipeg; E. A. McCusker, Regina; H. E. MacDermot, Montreal; H. K. MacDonald, Halifax; J. S. McEachern, Calgary; F. D. McKenty, Winnipeg; K. A. MacKenzie, Halifax; W. J. P. MacMillan, Charlottetown; Harris McPhedran, Toronto; J. D. McQueen, Winnipeg; A. G. Nicholls, Montreal; F. S. Patch, Montreal; T. A. Patrick, Yorkton; H. E. Preston, Brockville; A. Primrose, Toronto; George Ramsay, London; T. R. Ross, Drumheller; T. C. Routley, Toronto; J. H. L. Simpson, Springhill; A. H. Spohn, Vancouver; G. S. Stevens, Winnipeg; J. Stevenson, Quebec; G. F. Strong, Vancouver; F. F. Tisdall, Toronto; O. C. Trainor, Winnipeg; C. J. Veniot, Bathurst; Charles Vezina, Quebec; C. H. Walton, Winnipeg; A. B. Whytock, Niagara Falls; G. E. Wight, Montreal; R. G. Williams, Calgary; Wallace Wilson, Vancouver; R. E. Wodehouse, Ottawa; C. F. Wylde, Montreal; H. M. Yelland, Peterborough, A. W. Young, Montreal; and Geo. S. Young., Toronto

Messages of regret at inability to be present were received from Dr. Hermann Robertson, of Victoria, Dr. W. S. Peters, of Brandon and Dr. W. A. Jones of Kingston.

REPORT OF THE COMMITTEE ON ARCHIVES

Mr. Chairman and Members of General Council:—

Your Committee on Archives reports with regret the loss of the following members by death during the past year:—

Aiken, L. R., Courtright, Ontario
Alger, H. H., Stirling, Ontario
Anderson, J. E. W., Scotland, Ontario
Archibald, S., Edmonton, Alberta
Beech, S. E., Salmon Arm, British Columbia
Biggar, J. L., Toronto, Ontario
Blackhall, B. C., Toronto, Ontario
Brown, G. A., Winnipeg, Manitoba
Brydone-Jack, W. D., Vancouver, British Columbia (Senior Member)
Chase, W. H., Montreal, Quebec
Cerswell, W. A., Toronto, Ontario
Chandler, Edward B., Montreal, Quebec
Clendenan, G. W., Toronto, Ontario
Cowley, D. K., Granby, Quebec
Cunningham, A. R., Halifax, Nova Scotia
Drew, J. M., Lachute, Quebec
Esler, John, Cereal, Alberta
Fournier, Noe, Montreal, Quebec
Fraleigh, A. E., St. Mary's, Ontario
Fraser, J. J., Hamilton, Ontario

Grant, Percy, Winnipeg, Manitoba
Hamilton, J. H., Revelstoke, British Columbia
Henderson, G. B., Creston, British Columbia
Hendry, W. B., Toronto, Ontario
(Former Chairman, Committee on Maternal Welfare)
Houston, P. J. F., Toronto, Ontario
Hume, G. L., Sherbrooke, Quebec
Johnson, H. E., Mount Albert, Ontario
Keene, W. H., Nanton, Alberta
Kerr, W. A., Elora, Ontario
Lafleur, H. A., Montreal, Quebec
Ledwell, R. J., Charlottetown, Prince Edward Island
Llorens, F., Sheet Harbour, Nova Scotia
Loudon, T. G., Peterborough, Ontario
Mills, George, Alsask, Saskatchewan
Milne, G. L., Victoria, British Columbia
Moles, E. B., Brockville, Ontario
Murphy, J. G., New York, N.Y.
(Formerly Severn Bridge, Ontario)
Murray, H. G., Owen Sound, Ontario
Myles, E. R., Windsor, Ontario
Macartney, C. B., Thorold, Ontario
Macdonald, J. C., Edmonton, Alberta
MacDonald, J. J., New Glasgow, Nova Scotia
MacDougall, N. E., Vancouver, British Columbia
McGregor, S. R., Drumheller, Alberta
MacKay, D. W., Nelson, British Columbia
MacKay, H. H., New Glasgow, Nova Scotia
(Senior Member)
MacKenzie, A. J., Toronto, Ontario
(President—Ontario Division)
MacLeod, Daniel A., Sydney, Nova Scotia
MacLeod, Frank, Burnside, Nova Scotia
McLurg, Robert A., Wilkie, Saskatchewan
MacMillan, J. L., Westville, Nova Scotia
MacMurchy, J. A., Dresden, Ontario
Macphail, Sir Andrew, Montreal, Quebec
(Formerly Editor, C.M.A. Journal)
Pratt, John I., Port Arthur, Ontario
Richmond, L. A., Hamilton, Ontario
Robertson, J. Mair, Vancouver, British Columbia
(Senior Member)
Ross, H., New Glasgow, Nova Scotia
Royce, Gilbert, Toronto, Ontario
Rutherford, James W., Chatham, Ontario
Ryan, E., Kingston, Ontario
Scott, R. F., Toronto, Ontario
Sinclair, Ernest E., Summerside, Prince Edward Is.
Smith, D. M., Madsen, Ontario
Telford, Robert, Vancouver, British Columbia
Thistle, W. B., Toronto, Ontario
Vallee, Arthur, Quebec, Quebec
VanWart, G. C., Fredericton, New Brunswick
(New Brunswick Representative on Executive Committee)
Walkey, L. W., Lethbridge, Alberta
Wetmore, F. H., Hampton, New Brunswick
Wood, J. F., Manitou, Manitoba

The number of Questionnaires of personal information from members received to date is as follows:

First Series, 1927-28.....	1,988
Second series, 1938-39.....	1,342
Total.....	3,330

With a membership of 4,064 in December, 1938, this is considered fairly satisfactory.

A small amount of material, including two manuscripts, has been added to the Archives, but it has not been an outstanding year in this respect.

Your Committee would welcome receipt of any material of interest which may still be in possession of members of the Council and others of the Association.

All of which is respectfully submitted.

C. F. WYLDE,
Chairman.

Approved.

REPORT OF THE EXECUTIVE COMMITTEE

Mr. Chairman and Members of General Council:—

Your Executive Committee begs to report as follows:

MEETINGS OF THE COMMITTEE

The Committee has met three times during the year. A fourth meeting will be held in Montreal immediately prior to the Convention. With the exception of the first meeting which was held at Halifax and occupied half a day, each subsequent meeting has occupied two full days' time. The attendance has been excellent, there being four absentees from the first meeting, no absentees from the second and four absentees from the third. In addition to the various items which are reported upon from time to time to General Council and in the *Journal*, it should be mentioned that many other matters require the attention of the Executive Committee in the course of the year's activities.

Approved.

DOCTOR G. C. VANWART

Your Executive Committee reports with profound regret the loss by death of one of its members, in the person of Doctor G. C. VanWart of Fredericton, N.B. Doctor VanWart, throughout a long life of active medical service, was untiring in his zeal and efforts on behalf of organized medicine both in his own Province and in Canada as a whole. We shall miss not only his wise council but his cheery smile and kindly word.

On the recommendation of the New Brunswick Branch, Doctor A. E. Macaulay of Saint John was elected to succeed the late Doctor VanWart on the Executive Committee.

Approved.

ANNUAL MEETING, 1938

The annual meeting of 1938 was held in conjunction with the annual meeting of the Medical Society of Nova Scotia in the city of Halifax during the week of June 20th. One year previously, while attending the Ottawa meeting, the President-Elect and Mrs. MacKenzie together with their colleagues who were present from Nova Scotia, began to lay plans for the meeting a year hence. Throughout that entire year, the local and Provincial Medical Societies ably flanked by a thoroughly organized Women's Committee, continued to plan for the reception and entertainment of the Association when it should come to Halifax. That their efforts were entirely successful will be vouched for by the more than 1,000 members and friends who were privileged to attend the meeting. The Association is under a deep debt of gratitude to our Halifax and Nova Scotia hosts and hostesses, and to each one General Council will no doubt desire to express on this first occasion since the Halifax meeting its sincere appreciation.

Approved.

ANNUAL MEETING, 1939

The "Gentleman with the Note Book" throughout the Halifax meeting was none other than President-Elect, Dr. F. S. Patch of Montreal, who, keenly alive to the desirability of making the Montreal meeting fully in step with the tempo which had been set in Nova Scotia, was leaving no stone unturned to lay plans for the next meeting. Immediately upon returning home, Dr. Patch began to make arrangements for this year. It was early evident that the Quebec Division of the C.M.A., the Medico-Chirurgical Society of Montreal and the ladies associated with the two organizations were keenly interested in making the Montreal meeting highly successful from every point of view. A perusal of the program which is now available will disclose to General Council with what thoroughness plans for the meeting have been carried through. General Council will no doubt wish to compliment the host societies and all associated with them for what promises to be an outstanding week in the history of the Canadian Medical Association.

Approved.

PROVINCIAL MEETINGS

During the month of September 1938, the President and Mrs. MacKenzie accompanied by the General Secretary attended medical conventions from North-Western Ontario to the Pacific coast. The Association is indebted to the President and Mrs. MacKenzie for the notable service rendered by them, not forgetting the very long journey entailed in crossing Canada twice from coast to coast. We are assured that the Provincial Associations very greatly appreciated the presence of the President and his wife at their conventions.

During the month of January, the General Secretary made a tour of Western Canada when he was privileged to meet with Councils of the Colleges of Physicians and Surgeons, Boards of Directors of the Medical Associations and numerous Committees for the purpose of discussing problems of mutual interest.

Dates for Provincial Annual Meetings for the coming summer and autumn have already been set in the Provinces of Nova Scota, Prince Edward Island, New Brunswick, Manitoba, Saskatchewan, Alberta and British Columbia. The President and General Secretary hope to attend these meetings.

Approved.

FEDERATION

At our last annual meeting, it was reported that, as of that date, two Provinces, namely, Alberta and Quebec, enjoyed divisional status in the Association. At the Halifax meeting, applications to become Divisions were received from British Columbia, Saskatchewan, Ontario, Nova Scotia, and Prince Edward Island, all being approved by General Council. Subsequently, these Provinces submitted copies of their Constitution and By-Laws to the Association for approval. On the recommendation of the Association's Committee on Constitution and By-Laws, approval has been granted. This now makes seven provincial medical associations having completed divisional status within the Association. Negotiations have been carried on during the year with the Provinces of Manitoba and New Brunswick, by the Committee on Constitution and By-Laws, looking to the consummation of federation within these two Provinces. Whatever progress has been made in this direction will be reported by that Committee.

Approved.

Discussion in Council participated in by delegates from Manitoba and New Brunswick clearly indicated that these two provinces might be expected to vote favourably on Federation at their annual meetings to be held this autumn. In such event General Council provided by resolution that application for divisional status from either or both provinces could be granted to take effect as of January 1st, 1940.

MEMBERSHIP

As we go to press, our membership and subscriptions are as follows:

Province	*Membership*		*New Members*	*Subscriptions*	
	1938	*1939*	*1939*	*1938*	*1939*
British Columbia..	368	373	58	18	12
Alberta.....	536	560	..	34	33
Saskatchewan.	218	251	73	5	4
Manitoba....	169	165	9	15	14
Ontario.....	1720	1512	91	241	203
Quebec.....	539	620	89	48	45
New Brunswick..	138	137	7	3	2
Nova Scotia..	328	248	10	10	6
Prince Edward Island.....	48	38	2	..	..
United States.	44	13	..	274	269
Miscellaneous.	..	17	6	79	81
	4108	3934	345	730	669

Your Committee reported last year that a conjoint fee, including the C.M.A. fee had been established in the Provinces of Nova Scotia and Ontario, with gratifying results. As provided for under federation, all seven Divisions are collecting the C.M.A. fee this year. It will be observed that this has resulted in the securing of a number of new members. It is confidently hoped that, in the not far distant future, each Division will find it possible to collect from all its members a composite fee which includes that portion required for the Canadian Medical Association, which, at the present time, has been set at $8.00. General Council will recall that, in making a reduction of 20 per cent in our annual fee, a notable increase in membership was looked for, and, unless such increase is realized, our financial resources are bound to be impaired under the new arrangement rather than strengthened, because it must always be remembered that a physical asset, namely the *Journal*, which costs a considerable amount of money to produce, has to be provided every member of the Association; and while we have reduced our membership fee 20 per cent, we do not enjoy any reduction in the cost of publication of the *Journal*. A discussion in General Council as to ways and means of increasing membership in the Association is invited.

Approved.

CANCER

At the last annual meeting, it was reported to General Council that steps had been taken during the previous year, by the Executive Committee, to set up a Department of Cancer Control within the Association, and a Canadian Society for the Control of Cancer which responsibilities were laid upon the Association at the Ottawa, meeting in 1937, when a grant of $14,000 a year was accepted from the Board of Trustees of the King George V Silver Jubilee Cancer Fund for Canada.

As the General Secretary was appointed Chairman of the Board of Directors of the Department of Cancer Control, and director of its operations, the activities of the Department, as carried on during the past year, are reported upon herein. Other matters of general interest concerning the control of cancer will be dealt with by the Study Committee on Cancer of which Dr. J. S. McEachern of Calgary is Chairman.

The Board of Directors of the Department of Cancer Control met in Toronto on October 31st, 1938, with all members present, including representatives from every Province. During the year, the nucleus of the Board has met on several occasions, and, keeping in close touch by correspondence with the provincial members of the Board, has endeavoured to work out a cancer program which would appear to come within the orbit of the Association. Your Board was of the opinion that the following activities should engage its attention:

(1) The organization of cancer study groups in all hospitals in Canada with 100 beds and over, and in smaller hospitals where the medical staffs desire such cancer study groups to be organized.
(2) Preparation and distribution to the medical profession of literature dealing with the subject of cancer.
(3) Providing lectures on cancer subjects to organized medical societies.
(4) Preparing suitable material for lectures on the subject of cancer by doctors,—
  (*a*) to medical audiences; and
  (*b*) to the public.
(5) The preparation of literature on the subject of cancer for publication and distribution to the general public.
(6) Co-operation with the Canadian Society for the Control of Cancer in every direction in which such co-operation appears to be in the interests of the two organizations.

CANCER STUDY GROUPS

Under the Chairmanship of Dr. William A. Scott, a sub-committee was appointed to consider what record forms should be made available to hospital study groups. After long and careful consideration the sub-committee

recommended that there be provided to all study groups a brief, concise record form which would be used in reporting each cancer case to this Department for statistical purposes. The sub-committee further recommended that no attempt should be made to provide a standardized form to be used as a history form in all hospitals, but rather that this was a matter which should be settled according to the individual and local needs of the hospitals concerned. However, the committee did undertake to render any assistance it could by way of advice, or scrutiny of forms submitted for the purpose, by any hospital requiring such assistance.

Reporting forms have been printed and distributed to the nine Provinces, and critical analyses of history forms submitted to the Committee have been made and reported back.

Medical Literature

The Authorship Committee under the Chairmanship of Dr. Roscoe R. Graham, some months ago completed its task of producing a Handbook on Cancer, with the valuable assistance of the Medical Faculties of the several Medical Schools of Canada who collaborated in reviewing the various chapters of the book. Subsequently, 10,500 copies of the Handbook were printed and distributed to the medical profession across Canada. Following the distribution of the book, the Department has received a number of commendatory messages with regard to its value. The *British Medical Journal* of December 31st, 1938, carried a most complimentary editorial on the Handbook. Following its publication, more than one hundred orders were received from various parts of the British Empire outside of Canada.

Future Policy

Under the Chairmanship of Dr. George S. Young, a sub-committee was appointed to study the background of the Department and outline its future policy. The sub-committee reports in part as follows:

The Department of Cancer Control has been set up by the Canadian Medical Association to focus the attention of physicians throughout Canada on the cancer problem; to concentrate their efforts in an endeavour to bring about better control of the disease and to take whatever part is required in the education of the public.

With regard to the part which individual physicians everywhere throughout the land may play in the program of cancer control, the sub-committee has the following to say:

Previous History Research

All organization, no matter how carefully planned, will fail to reach its objectives unless it has not merely the passive interest but rather the enthusiastic co-operation of its members at large. As a result of the activities already planned by the Department of Cancer Control, the doctor may read more about the disease; he may become more alert as to the need for careful examination, early diagnosis and effective treatment; he may become more impressed with the importance of educating his patient as to the value of periodic health examinations and of the apparently trivial signs suggestive of cancer. But if he can be invited to work on a problem in clinical research, for which every practising physician is qualified, there is a fair chance of getting his active, personal interest. Whether such research would be of value might be open to question, even if the results were collected by the Department of Cancer Control and carefully studied; but undoubtedly the time has come for investigation of the antecedents of cancer. What is wanted is an accurate and minute detail of the family and personal history of all cancer patients. Scientific research now and in the past has concerned itself with the study of the nature of cancer and the effect of treatment. Cancer has been produced experimentally by various agents and some of these are known to cause the disease in human beings. But the belief is now expressed by those engaged in scientific research that there are other remote factors which may be active for years before the final transformation of the body cell into one which is malignant. It has been urged that the time has come to follow back in the history in the hope of finding out more about these remote factors; in other words, to look for ways of preventing cancer.

Note.—It is hoped that the formation of Cancer Study Groups within hospitals will do much to shed additional light on the subject.

Medical Publicity

In addition to what has already been accomplished in producing an authoritative book on cancer, there are two other fields of activity:

(1) Provision to be made for addresses and clinics for larger groups of doctors who attend local, District, Provincial and Dominion Medical Meetings.

Note.—During its first year of operation, the Department provided a speaker on cancer, in the person of Dr. A. T. Bazin of Montreal, to address several Provincial Medical Association Conventions. This coming autumn, Dr. Roscoe R. Graham of Toronto will perform a similar function when he addresses the annual meetings in the Provinces of British Columbia, Alberta, Saskatchewan and Manitoba.

(2) It is suggested that the Department of Cancer Control should endeavour to secure a single column in each issue of the *Journal* for material on cancer.

Note.—Readers of the *Journal* will be familiar with the fact that, during the past several months, each issue has carried some interesting material on the subject of cancer.

Lay Publicity

The sub-committee recommended that the Department of Cancer Control reaffirm its desire to co-operate in every possible way with the Canadian Society for the Control of Cancer in the preparation and presentation of authentic information which would assist the general public to cooperate on its own behalf, in the further control of cancer.

Note.—This is being carried out through the Bulletin of the Canadian Society for the Control of Cancer.

Cancer a Reportable Disease

In some of the Provinces of Canada, cancer is now a reportable disease. Considerable weight attaches to the recommendation that a similar regulation should exist in every Province. This suggestion is being explored.

Organization

Our country is so large and medical problems so many and varied that the organization of the Department of Cancer Control has not proceeded as rapidly as some had hoped for. However, support of the movement is not lacking in the profession, and evidence is now before us that the Provincial Committees are endeavouring to set up the necessary study groups and in other directions put machinery in motion which should tend to accelerate the interest of the profession in the subject and bring to bear upon it a greater measure of control. Education of the profession and the public, early diagnosis, prompt and efficient treatment,—all of these things working together can and will reduce cancer mortality in Canada.

Approved.

Senior Members

We quote hereunder from our By-Laws, Chapter 2, Section 3, Senior Members:

"Any member of The Association in good standing for the immediately preceding ten-year period who has attained the age of seventy years, is eligible to be nominated for Senior Membership by any ordinary member of The Association, but may be elected only by the unanimous approval of the members of the General Council in session present and voting. Not more than ten such Senior Members may be elected in any one year. Senior Members shall enjoy all the rights and privileges of The Association, but shall not be required to pay any annual fee."

Your Executive Committee has pleasure in recommending the following gentlemen for election to senior membership, each being eligible under the provisions of the By-Law:

Dr. Thomas Alfred Patrick, Yorkton, Sask.
Dr. W. Harvey Smith, Winnipeg, Man.
Dr. John Graham, Bolton, Ontario
Dr. Robert Dawson Rudolf, Toronto, Ontario
Dr. Joseph Edmond Dubé, Montreal, Que.
Dr. Hubert Douglas Hamilton, Montreal, Que.
Dr. John M. Barry, Saint John, N.B.
Dr. Charles Ashton Webster, Yarmouth, N.S.
Dr. Walter Stuart Galbraith, Lethbridge, Alta.
Dr. Ivan Glen Campbell, Vancouver, B.C.

Approved.

Places of Annual Meetings

General Council having designated the places of meeting for the years 1939, 1940 and 1941, your Executive Committee begs to report that dates of meetings for the next two years have been set as follows:

1940—Toronto, June 17, 18, 19, 20, 21.
1941—Winnipeg, June 22, 23, 24, 25, 26.

In connection with the Toronto meeting in 1940, the complete convention facilities of the Royal York Hotel have been secured. With regard to the Winnipeg meeting in 1941, the dates selected have been communicated to the Manitoba Branch, and no doubt such preliminary steps as seemed necessary to the Branch have already been taken.

Approved.

It was suggested that, with the approval of the Divisions concerned, the annual meeting in 1942 be held in the Province of Alberta; in 1943 in Montreal, and in 1944, in the Province of Saskatchewan.

Radio Broadcasting

For some considerable time, your Executive Committee has had under consideration a proposal from the Canadian Broadcasting Commission which, if adopted, would provide for a regular program over CBC, sponsored by the Association. A sub-committee under the chairmanship of Dr. T. H. Leggett of Ottawa has been appointed to confer with the General Manager of the Canadian Broadcasting Corporation, and a supplementary report dealing with this subject will be available to General Council at this session.

Approved.

In a supplementary report on this matter it was announced that the Canadian Broadcasting Corporation desired the Canadian Medical Association to provide a fifteen minute health talk once a week from autumn until spring; and, during the intervening months, a fifteen minute health talk once a month; or, roughly, 32 broadcasts during the year. The Canadian Broadcasting Corporation is willing to provide funds to the Canadian Medical Association to pay the necessary expenses incurred in producing the broadcasts. This plan was approved in principle and arrangements for putting it into effect were delegated to a committee under the Chairmanship of Dr. T. H. Leggett, with power to add.

National Emergency

During the past several months, your Committee has had under consideration what appropriate action should be taken by the Canadian Medical Association in the event of a national emergency being precipitated. During the Great War and again within more recent months, the British Medical Association by the use of a questionnaire, has classified and categorized the medical profession of the United Kingdom, in order that in an emergency the services of the profession might be most satisfactorily utilized, both at home and in theatres of war. What has been done in Great Britain has been carried out with the full knowledge, co-operation and approval of the Government. Your Executive Committee, after carrying on a number of preliminary discussions with the Departments of Government concerned, appointed a special Committee under the Chairmanship of Dr. W. H. Delaney of Quebec to study the whole problem. There will be available to General Council a supplementary report from the special Committee when this item is under discussion.

Approved.

Dr. W. H. Delaney presented a Supplementary Report in which analysis was made of the problem and various suggestions brought forward as to how it might be dealt with. General Council finally agreed that the Executive Committee should further explore the whole matter and request an audience with the Prime Minister to discuss it.

Immigration

It was to be expected that among the many refugees of European countries seeking asylum in Canada, there would be a certain number of medical practitioners. Having given this subject considerable thought and study, and having discussed it with the Departments of Government concerned, your Executive Committee desires to place on record the following recommendation:

While the Committee sympathizes with the unfortunate plight into which our colleagues in medicine, who are exiles from their own country, have been placed, yet, under existing conditions in Canada, it would seem impossible to encourage immigration of these refugees for the following reason: That, having carefully reviewed the situation, this Executive Committee is of the opinion that the Medical Schools of Canada are graduating more than a sufficient number of doctors for Canadian needs, and, in the opinion of this Committee, there is at present no need for the importation or admission of doctors into Canada; and, further, your Executive Committee recommends to the Prime Minister of Canada that no medical refugees intending to practise medicine in Canada be admitted into the country.

It might further be stated that our attention has been drawn to the fact that representations have been made to Government that there are sections of Canada now without medical practitioners which could be served by foreign-born doctors if they were permitted to take up residence in this country. It is the view of your Executive Committee that a Canadian graduate is usually available for any section of Canada which can be expected to provide a living to a resident physician.

Conversely, it is not believed that sparsely settled areas which are now without doctors would find their medical problems solved if foreign-born doctors were admitted at this time. In further reference to this matter your Executive Committee desires to submit the following resolution:

That, having regard to the fact that, during the past fifteen years, the Canadian Medical Association through its branches and its central office, has assisted in placing thousands of doctors, this Executive Committee goes on record as prepared to assist in so far as we are able, any other authority or organization in supplying medical services to any area in Canada requiring such services; but that, in our opinion, there is at present no need for the importation or admission of doctors into Canada for the specific purpose of practising medicine; and that the Chairman of this Executive Committee and the General Secretary be instructed to present this resolution to the Prime Minister of Canada.

Approved.

It was duly moved, seconded and agreed that the resolution and recommendations in the Section of the Report of the Executive Committee dealing with Immigration be forwarded to each of the licensing bodies in Canada as an expression of opinion of the profession with regard to the admission of alien physicians into Canada.

MEDICAL ECONOMICS

At the March meeting of the Executive Committee, Dr. Wallace Wilson of Vancouver, Chairman of the Association's Committee on Economics, attended by invitation, to discuss with the Committee some problems related to the present status of medical economics in Canada. Prior to this meeting, Dr. Wilson endeavoured to secure by way of questionnaire, expressions of opinion from the nine Provinces on a number of pertinent points relating to the problem. The Executive Committee has asked the Committee on Economics to embody in its report to General Council an outline containing the salient features of this special report to the Executive Committee. Your Executive Committee wishes to say here, however, that certain recommendations made to it by the Committee on Economics have been taken under advisement by a sub-committee of which Dr. T. H. Leggett was made Chairman, and the recommendations of this sub-committee will be available to General Council when the report of the Committee on Economics is under discussion.

Approved.

CEREMONY

With each succeeding year during the past decade, it has become more and more apparent to your Executive Committee that the conduct of an annual meeting should be covered by ceremonial procedure which would make adequate and proper provision for the many aspects of an annual meeting such as our Association now desires to hold. With that thought in view, a Ceremonial Committee has been at work for several years. This year, under the Chairmanship of Dr. A. T. Bazin of Montreal, the Committee has endeavoured with most meticulous care to outline procedure for an annual meeting from its beginning until its end. It seems unnecessary for your Executive Committee to present this plan in detail but it is hoped that General Council will recognize and approve what has been done; and further that members of General Council will be good enough to make suggestions whenever it is felt that procedure may be improved upon.

Approved.

THE FREDERIC NEWTON GISBORNE STARR MEMORIAL AWARD

In connection with the Frederic Newton Gisborne Starr Memorial Award, it has been found that no date has been set for receiving nominations for this award.

On the recommendation of the Committee on Awards, Scholarships and Lectures, your Executive Committee passed the following resolution which is now referred to General Council for approval:

(1) That all nominations for this award must be submitted in writing and forwarded to the Chairman of the Committee on Awards, Scholarships and Lectures through the General Secretary of the Association at least six months prior to the next Annual General Meeting of the Association.

(2) That recommendations for this award must be approved by the Executive at a meeting held at least two months prior to the next Annual Meeting.

Approved.

MEDICAL RESEARCH JOURNAL

A communication was received by the Executive Committee from the Associate Committee on Medical Research asking for an expression of opinion from the Association as to the advisability of publishing a Medical Research Journal in Canada; also asking for some indication as to the measure of support either financial or in the contribution of papers, which might be expected from the Canadian Medical Association if it were decided to publish such a Journal. The following resolution was passed by the Executive Committee:

"That this Executive Committee express itself as favourable to the publication of a Medical Research Journal by the Associate Committee on Medical Research; and that the Chairman and General Secretary be requested to confer with General McNaughton with reference to the whole matter."

A supplementary report will be available on this item.

Approved.

CONCLUSION

It is just ten years since the Association last met in the City of Montreal. In glancing back over this period, certain observations might properly be made. Financially and industrially, and in many other ways, they have been ten lean years for the country. We have apparently gone from one economic depression to another. We have witnessed devastating crop failures in Western Canada. We have had the spectre of war staring us in the face. The statistician of the future will probably describe this period with a downward curve; but the picture is not by any means all black. The Canadian Medical Association can look back over the period as one of some progress. Our membership has held up exceedingly well. We have strengthened our ranks most notably in the direction of federation, with seven of the nine Provinces now being active Divisions, and prospects for the consummation of Federation being very bright indeed.

While our financial resources, particularly in relation to gift funds have not been what they formerly were, yet by way of national, provincial and local medical society meetings and in other activities, the progress of medicine has not been curtailed, but, on the contrary, has marched steadily forward. Your Executive Committee believes that the Canadian Medical Association has a very definite and important part to play in the life of this country. Furthermore, your Committee reaffirms its belief that the Association is continuing to live up to its aims and objects and is discharging its obligations in a manner which should call for the support and allegiance of every medical practitioner in Canada.

All of which is respectfully submitted.

T. H. LEGGETT,
Chairman.

T. C. ROUTLEY,
General Secretary.

Approved.

REPORT OF THE COMMITTEE ON CREDENTIALS AND ETHICS

Mr. Chairman and Members of General Council:—

As Chairman of the Committee on Credentials and Ethics I beg to report as follows:

A translation into French of the Code of Ethics of the Canadian Medical Association was submitted to the meeting of the Executive Committee of the Association in March. That translation is now being revised under the direction of Dr. Gérin-Lajoie, a member of the Executive Committee.

Several questions submitted to the Committee during the year for consideration were discussed. Those subjects dealt with popular radio talks on medicine; the insertion of a professional card in the local press; and charges of unscrupulous protection given to doctors by the Medical Protective Association, and two charges of malpractice. These charges were investigated and the Committee felt that they were not substantiated.

An article on the Code of Ethics of the Canadian Medical Association appeared in the *Canadian Hospital*, the official journal of the Canadian Hospital Council.

The assistance of other members of the Committee on Credentials and Ethics, of members of the Executive Committee, of the General Secretary, and of other medical men is remembered with gratitude. In particular I wish to mention the kind aid in the preparation of the Code of Ethics given by Dr. Alfred Cox, London, England, former General Secretary of the British Medical Association, and of Dr. James Grassick, Grand Forks, N.D., whose counsel on knotty points came from a wealth of experience.

All of which is respectfully submitted.

ROSS MITCHELL,
Chairman.

Approved.

REPORT OF THE HONORARY-TREASURER

Mr. Chairman and Members of General Council:—

I have the honour to submit statements of the various funds duly audited by Messrs. McDonald, Currie & Company.

Our revenues from membership fees and subscriptions have shown an increase of $294.13 and the profit on the annual meeting amounted to $1,479.30.

On the other hand expenses in certain departments have been higher than those of 1937 and the Association made a grant of $2,000.00 to the Manitoba Pregnancy Survey. Although the financial operations of the year 1938 have not been as favourable as those of 1937, we are able to report a credit balance of $4,167.96.

To the Association's investment account has been added $5,000.00 of Prince Edward Island Deposit Certificates paying 3 per cent. These certificates are in the nature of a call loan but rank with trust fund securities of the Province. Owing to the uncertainty of the present low rates of interest and the generally unsettled state of affairs a strong liquid position was considered advisable and no further moneys were invested.

BLACKADER LIBRARY

We are gratified to report the receipt of a legacy of $1,200.00 from the late Mrs. A. D. Blackader to the Blackader Library of the Hospital Service Department. After the establishment of this library, Dr. Blackader made an annual contribution of $50.00 for the purchase of books and journals. At his request these donations were continued by Mrs. Blackader until the time of her death last year. This legacy represents the final contribution to our Association of a man who for ten years acted as editor of the *Journal* on a purely honorary basis, and to whom the present excellent state of the *Journal* is a lasting memorial.

All of which is respectfully submitted.

D. SCLATER LEWIS,
Honorary Treasurer.

AUDITORS' REPORT

Montreal, 16th February, 1939.

Dr. D. SCLATER LEWIS,
Honorary Treasurer,
Canadian Medical Association,
3640 University Street, Montreal.

Dear Sir:—

We beg to report that we have completed an audit of the books and accounts of the Association for the year ended 31st December, 1938.

The receipts and disbursements of the General Secretary in Toronto, as shown on a statement certified to by Mr. Dignam as Auditor, have been incorporated in the books.

We verified the cash on hand and in Bank and received confirmation of the securities which are held in safekeeping for Investment Account and for Trusts.

We found the books and accounts in excellent order and were given every assistance in the conduct of our audit.

Subject to the above remarks, we report that, in our opinion, the attached Balance Sheet is properly drawn up so as to exhibit a true and correct view of the state of the Association's affairs as at 31st December, 1938, according to the best of our information and the explanations given to us and as shown by the books.

Yours faithfully,

(Signed) McDONALD, CURRIE & Co.,
Chartered Accountants.

STATEMENT No. 1

BALANCE SHEET AS AT 31ST DECEMBER, 1938

ASSETS			LIABILITIES		
Cash on Hand:			Accounts Payable		$ 3,615.96
Montreal		$ 25.00	Advertising Prepaid		133.27
Cash in Bank:			Prepaid Membership Fees, 1939..	$615.00	
Montreal	$20,364.84		Prepaid Subscriptions, 1939	271.87	
Toronto:					886.87
General Funds..	78.57		Trusts—as per Schedule No. 2		31,665.38
Annual Meeting.	2,677.62		Special Grants—as per Schedule No. 3		8,585.40
		23,121.03			
		$23,146.03	SURPLUS ACCOUNT:		
ACCOUNTS RECEIVABLE:			Balance at Credit, 1st January, 1938	$86,244.60	
Advertising	$1,627.35		*Add*—Amount recovered from Cancer Fund for operation of Department of Cancer Control for 1937 (Nine Months)	3,750.00	
Reprints	303.91		Excess Revenue for Year—as per Statement No. 2	4,167.96	
Printing	439.33				94,162.56
Trust Funds and Special Grants	608.25				
		2,978.84			
INVESTMENTS:					
At Book Value, Schedule No. 1	$70,816.75				
Accrued Interest on Investments	537.40				
		71,354.15			
Deferred Charges		27.43			
Copies of History of Canadian Medical Association on Hand (at net cost)		732.22			
Trust Funds—as per Schedule No. 2		31,665.38			
Special Grant Funds—as per Schedule No. 3.		8,585.40			
Furniture and Fixtures—*Less* Depreciation		559.99			
		$139,049.44			$139,049.44

Submitted subject to our report of this date.

(Signed) McDONALD, CURRIE & Co.,
Chartered Accountants.

Montreal, 16th February, 1939.

STATEMENT No. 2

STATEMENT OF REVENUE AND EXPENDITURE FOR YEAR ENDED 31ST DECEMBER, 1938

REVENUE		EXPENDITURE		
Membership Fees	$33,238.98	JOURNAL EXPENSES:		
Subscriptions	3,697.01	Printing	$25,055.46	
Advertising	30,118.18	Illustrations	810.97	
Special Reprints	197.83	Agents' Commission	3,368.52	
Sundry Sales of *Journal*	217.88	Editorial Salaries	8,757.00	
Excess Revenue from Annual Meeting	1,479.30	Editorial Expenses	1,014.38	
Revenue from Investments	2,508.90			$39,006.33
		ADMINISTRATION AND FINANCIAL EXPENSES:		
		General Expenses	$ 506.79	
		Travelling Expenses	5,575.93	
		Office Expenses—General Secretary	201.31	
		Postage	1,239.23	
		Salaries—General Secretary	13,500.00	
		Other	8,253.50	
		Stationery and Printing	981.67	
		Telephone and Telegrams	359.04	
		Bad Debts	30.60	
		Discount and Exchange (Net)	573.50	
		Depreciation of Furniture and Fixtures	62.22	
			$31,283.79	
		Less—Recovered from Cancer Fund for Operation of Department of Cancer Control	5,000.00	
				26,283.79
		Contribution to Manitoba Medical Association for Special Survey		2,000.00
		Excess Revenue for Year—Transferred to Surplus Account as per Balance Sheet		4,167.96
	$71,458.08			$71,458.08

SCHEDULE No. 1

SCHEDULE OF INVESTMENTS AS AT 31ST DECEMBER, 1938

GENERAL FUND

	Par Value	*Book Value*
City of Montreal 4½/46	$ 1,000.00	$ 975.00
City of Montreal 4½/47	2,000.00	1,856.20
City of Montreal 5/54	5,000.00	5,050.00
City of Montreal 6/44	500.00	542.50
Dominion of Canada 3/55	1,000.00	985.00
Dominion of Canada 3½/49	5,000.00	4,825.00
Dominion of Canada 5/43	100.00	98.25
Island of Montreal Metropolitan Commission 4½/62	8,000.00	8,220.00
Island of Montreal Metropolitan Commission 4½/61	1,000.00	1,000.00
Island of Montreal Metropolitan Commission 5/49	2,000.00	2,006.00
Jewish Hospital Campaign Committee Inc., of Montreal 5/46	5,000.00	4,950.00
Province of Alberta 4½/42	5,000.00	4,812.50
Province of British Columbia 4/57	5,000.00	4,775.00
Province of New Brunswick 4/47	10,000.00	10,100.00
Province of Nova Scotia 3/52	10,000.00	9,900.00
Province of Ontario 4½/39	1,000.00	986.30
Province of Prince Edward Island Deposit Receipt 3%	5,000.00	5,000.00
Province of Saskatchewan 4/54	1,000.00	900.00
Province of Saskatchewan 4½/60	3,000.00	2,835.00
Ritz-Carlton Hotel Co. 1st Mortgage 5/42	1,000.00	1,000.00
	$71,600.00	$70,816.75

Approximate Market Value, $67,693.00.

TRUST FUNDS

LISTER CLUB FUND:

City of Winnipeg 5/43	$4,000.00	$4,021.20
Province of Quebec 4½/63	1,000.00	985.00
	$5,000.00	$5,006.20

Approximate Market Value, $5,000.00.

OSLER MEMORIAL FUND:

Dominion of Canada 3/55	$2,000.00	$1,970.00
Dominion of Canada 3½/49	100.00	96.50
Pacific Great Eastern Railway 4½/42	500.00	497.65
Province of Alberta 4½/42	3,000.00	2,887.50
	$5,600.00	$5,451.65

Approximate Market Value, $4,294.25.

OSLER SCHOLARSHIP FUND:

City of Montreal 5/43	$5,000.00	$5,187.50
Island of Montreal Metropolitan Commission 5/42	5,000.00	5,162.50
Montreal Protestant Schools 5/52	2,000.00	1,995.60
	$12,000.00	$12,345.60

Approximate Market Value, $12,585.00.

BLACKADER LECTURE FUND:

City of Drummondville 4/56	$ 500.00	$ 517.50
City of Drummondville 4/62	100.00	103.50
Dominion of Canada 4½/46	200.00	195.00
Dominion of Canada 4½/57	200.00	204.00
Province of Alberta 4½/56	1,000.00	1,000.30
Three Rivers R.C. Schools 5½/44	3,000.00	3,030.00
	$5,000.00	$5,050.30

Approximate Market Value, $4,745.50.

SCHEDULE No. 2

SCHEDULE OF TRUSTS AND TRUST FUNDS AS AT 31ST DECEMBER, 1938

			Trust Funds	*Trusts*
LISTER CLUB FUND:				
Capital		$5,042.36		
Accumulated Revenue, 1st January, 1938	$971.54			
Revenue for Year	248.88			
		1,220.42		
				$ 6,262.78
Represented by—				
Investments as per Schedule No. 1		$5,006.20		
Cash in Bank		1,256.58		
			$6,262.78	
OSLER MEMORIAL FUND:				
Capital, 1st January, 1938		$5,564.16		
Accumulated Revenue, 1st January, 1938	$793.16			
Revenue for Year	85.42			
Loan from Canadian Medical Association	77.00			
	$ 955.58			
Deduct—Oration Expenses	1,042.30			
		86.72		
				5,477.44
Represented by—				
Investments as per Schedule No. 1		$5,451.65		
Cash in Bank		25.79		
			5,477.44	
OSLER SCHOLARSHIP FUND:				
Capital		$12,474.90		
Accumulated Revenue, 1st January, 1938	$1,500.69			
Revenue for Year	601.91			
	$2,102.60			
Deduct—Scholarships Awarded 30th June, 1938	1,800.00			
		302.60		
				12,777.50
Represented by—				
Investments as per Schedule No. 1		$12,345.60		
Cash in Bank		431.90		
			12,777.50	
BLACKADER LECTURE FUND:				
Capital		$5,000.00		
Accumulated Revenue, 1st January, 1938	$290.44			
Revenue for Year	204.05			
		494.49		
				5,494.49
Represented by—				
Investments as per Schedule No. 1		$5,050.30		
Cash in Bank		444.19		
			5,494.49	
BLACKADER LIBRARY OF THE HOSPITAL SERVICE DEPARTMENT:				
Balance, 1st January, 1938		$ 252.27		
Legacy Received During Year		1,200.00		
Bank Interest		2.07		
		$1,454.34		
Deduct—Expenditure for Books and Literature		82.19		
				1,372.15
Represented by—				
Cash in Bank			1,372.15	
CANADIAN RADIOLOGICAL SOCIETY LIBRARY FUND:				
Balance, 1st January, 1938		$315.53		
Bank Interest		1.42		
		$316.95		
Deduct—Expenditure for Books		35.93		
				281.02
Represented by—				
Cash in Bank			281.02	
			$31,665.38	$31,665.38

SCHEDULE No. 3

SCHEDULE OF SPECIAL GRANTS AND SPECIAL GRANT FUNDS AS AT 31ST DECEMBER, 1938

			Special Grant Funds	*Special Grants*
DEPARTMENT OF HOSPITAL SERVICE:				
Balance at Credit, 1st January, 1938		$ 849.52		
Grant from Sun Life Assurance Company of Canada		11,000.00		
Bank Interest		1.73		
		$11,851.25		
Deduct—Salaries	$8,440.00			
Travelling Expenses	998.51			
Printing, Stationery, Literature and Office Supplies	218.46			
Postage	373.06			
General Expenses	229.24			
Printing Special Report	750.00			
Depreciation of Equipment	67.58			
		11,076.85		
Balance at Credit, 31st December, 1938				$ 774.40
Represented by—				
Cash in Bank	$191.22			
Less—Account Payable	25.00			
		$166.22		
Furniture and Equipment—*Less* Depreciation		608.18		
			$ 774.40	
(Expenditure, $11,076.85; Revenue, $11,001.73; Excess Expenditure for Year, $75.12.)				
DEPARTMENT OF PUBLICITY AND HEALTH EDUCATION:				
Balance at Credit, 1st January, 1938		$2,915.67		
Deduct—Equipment Written Off		189.47		
		$2,726.20		
Grant from Canadian Life Insurance Officers' Association		3,000.00		
Bank Interest		21.55		
Royalties on "What You Should Know" Series		.98		
		$5,748.73		
Deduct—Salaries	$683.24			
Travelling Expenses	618.75			
Postage	145.15			
General Expenses	4.50			
Stationery, Printing and Literature	26.08			
Depreciation of Equipment	41.48			
		1,519.20		
Balance at Credit, 31st December, 1938				4,229.53
Represented by—				
Cash in Bank		$3,256.23		
Account Receivable		600.00		
Equipment—*Less* Depreciation		373.30		
			4,229.53	
(Revenue, $3,022.53; Expenditure, $2,119.20; Excess Revenue for Year, $903.33.)				
POST-GRADUATE DEPARTMENT:				
Balance at Credit, 1st January, 1938		$469.87		
Deduct—Depreciation of Equipment		46.99		
Balance at Credit, 31st December, 1938				422.88
Represented by—				
Equipment—*Less* Depreciation			422.88	
CANCER FUND:				
Balance at Credit, 1st January, 1938		$6,030.00		
Grant from Board of Trustees of King George V Jubilee Cancer Fund for Canada:				
For balance of 1937		3,000.00		
For 1938		14,000.00		
Bank Interest		131.28		
Sales of Handbook on Cancer		12.00		
		$23,173.28		
Deduct—Canadian Society for Control of Cancer	$5,000.00			
Cost of Handbook on Cancer	5,370.41			
Travelling Expenses of Cancer Lecturer	391.03			
Canadian Medical Association for Operation of Department of Cancer Control:				
For 1937 (nine months)	3,750.00			
For 1938	5,000.00			
		19,511.44		
Balance at Credit, 31st December, 1938				3,661.84

SCHEDULE No. 3—*Continued*

			Special Grant Funds	*Special Grants*
Represented by—				
Cash in Bank	$3,652.84			
Less—Account Payable	3.00			
		$3,649.84		
Account Receivable		12.00		
			$3,661.84	
COMMITTEE ON NUTRITION:				
Grant from London Life Insurance Company		$1,000.00		
Grant from Canadian Life Insurance Officers' Association		1,000.00		
		$2,000.00		
Deduct—Lecture Tour Sir Edward Mellanby	$1,330.00			
Lecture Tour Prof. L. H. Newburgh	400.00			
Lecture Tour Dr. McCollum	465.00			
Printing and Stationery (Tickets, etc.)	95.95			
General Expenses	112.30			
Posters	100.00			
		2,503.25		
Balance at Debit, 31st December, 1938				$ 503.25
Represented by—				
Account Payable to Canadian Medical Association			503.25	
			$8,585.40	$8,585.40

Approved.

REPORT OF THE CENTRAL PROGRAMME COMMITTEE

Mr. Chairman and Members of General Council:—

The general order of the Scientific Programme for the Annual Meeting is according to the plan followed for the past three Annual Meetings. The programme provides nineteen papers for the General Session and one hundred and eighteen papers for the meetings of thirteen Sections. In the selection of topics for discussion an earnest effort has been made to meet the general and special interests of members of the Association. Guest Speakers at General Session include Professors E. P. Cathcart, Professor of Physiology, University of Glasgow; Dr. Allen O. Whipple, Professor of Surgery, Columbia University, who will deliver the Lister Lecture; Dr. A. J. Bedell of Albany, New York; and Dr. Norman Miller, Professor of Obstetrics and Gynæcology, Ann Arbor, Michigan. Another Guest Speaker is Dr. Clara Davis of Winnetka, Illinois, who will address a meeting of the Section in Pædiatrics.

A new feature of the General Programme this year, suggested by the Local Programme Committee, is the introduction of Round-Table Conferences and Instructional Courses. It is the hope of your Committee that members of the Association will find these both interesting and instructive.

In conclusion, your Committee wishes to acknowledge the generous help and cooperation given in the preparation of the Scientific Programme by the Local Programme Committee under the efficient Chairmanship of Dr. J. C. Meakins, and to thank the many members of the Association who are contributing to the success of the Meeting by reading papers or by conducting Round-Table Conferences or Instructional Courses.

All of which is respectfully submitted.

DUNCAN GRAHAM,
Chairman.

Approved.

REPORT OF THE POST-GRADUATE COMMITTEE

Mr. Chairman and Members of General Council:—

When the Association's plan of extramural post graduate lectures made possible through the generosity of the Sun Life Assurance Company was discontinued on account of economic conditions the Association, not wishing to see this useful work stopped completely, agreed to send a team of speakers to the Western Provinces when the Annual Meeting is held in the East and *vice versa*. Arrangements have been made for a team of speakers to address the Annual Meetings of the four Western Provinces in September next. As the past two Annual Meetings have been held in Central or Eastern Canada and we are now meeting in Montreal a team of speakers will be sent to both the East and the West this year.

The hope is expressed that in the not too distant future our former plan of extramural lectures may be resumed.

All of which is respectfully submitted.

DUNCAN GRAHAM,
Chairman.

Approved.

REPORT OF THE EDITOR

Mr. Chairman and Members of General Council:—

We have to report a year of success since the date of the last Annual Meeting, in spite of certain handicaps. In order to keep within our budget we are maintaining the *Journal* at an average of 100 pages each issue. This means that much excellent material has had to be refused. During the year 305 papers were offered us, of which 268 were accepted for publication. Again, the program of the Montreal meeting is very lengthy, some 200 papers being listed. Of these only about two-thirds can be published. The best the *Journal* can do is to make a selection, having in mind variety and the general usefulness of the topics. In this situation contributors could help us much by keeping their offerings within narrower limits. No paper should exceed 16 quarto pages of typed MS, *double-spaced*, including tables and illustrations. Bibliographies should be limited to key-references, should follow the scheme required by the *Journal*, and should be *correct*. The situation suggests that as soon as feasible the *Journal* be issued at shorter intervals.

Our endeavour is to keep our readers informed as to the advances in medical science, both experimental and clinical, and, at the same time, to provide information that is of immediate practical value. We hope that every member will find something in each issue to interest *him*.

We cannot do more here than refer to a few of the outstanding papers that have appeared. Those that are more technical have a special importance in that they announce important discoveries or record steps in the development of medical problems. The others record clinical experiences. In the first group might be mentioned "Physiological Studies in Experimental Drowning" by Sir Frederick Banting, G. E. Hall, J. M. Janes, B. Leibel, and D. W. Lougheed; "Intranasal Administration of Œstrogenic Hormones in Constitutional Deafness" by H. Mortimer, R. P. Wright, D. L. Thomson, and J. B. Collip; "The Prevention of Silicosis by Metallic Aluminum" by J. J. Denny, W. D. Robson and D. A. Irwin; "The Influence of a Specific Hormone of the Pituitary on Basal Metabolism in Man" by I. M. Rabinowitch, M. Mountford, D. K. O'Donovan and J. B. Collip; "The Thermostability of Pituitary Extracts in Relation to Ketogenic Activity" by A. H. Neufeld and J. B. Collip; "The Antagonist to Adrenal Hyperglycæmia in Pituitary Extracts" by A. H. Neufeld and J. B. Collip; "Experimental Studies with Sulphanilamide and other Compounds", by P. H. Greey.

In the second group may be mentioned "Acute Anterior Poliomyelitis" by H. H. Hyland, W. J. Gardiner, F. C. Neal, W. A. Oille, and O. M. Solandt; "Comparative Chemotherapy in Experimental Pneumococcal Infections" by P. H. Greey, D. B. MacLaren and C. C. Lucas; "The Treatment of Pneumococcal Pneumonia with Dagenan" by D. Graham, W. P. Warner, J. A. Dauphinee and R. C. Dickson; "The Treatment of Pneumococcic Pneumonia with Sulfapyridine" by J. C. Meakins and F. R. Hanson; "Progress in Ophthalmology" by Sir Stewart Duke-Elder.

The Osler Oration by Sir Humphry Rolleston was a masterly effort.

Under the section of Men and Books "The Life of Sir Charles Tupper" by J. H. L. Simpson was noteworthy as giving the only account in our *Journal* of the career of our first president.

We have had several articles under the heading of Medical Economics, particularly on the subject of health insurance. Our General Secretary has contributed an exhaustive presentation of "Canadian Experiments in Medical Economics" which is of great informative value.

The section of Therapeutics and Pharmacology, designed to bring practical hints on diagnosis and treatment in a short compass to the notice of the general practitioner, is being continued. The series of special articles on Diet and Nutrition has run through the year and will shortly be completed.

A new section, The Cancer Campaign, has been started in the interest of the Association's cancer work and of the new Canadian Society for the Control of Cancer.

The editorials have been planned to cover subjects that were to the fore at the moment, and have been of wide range. Some of the topics covered were "Recent Amendments to the Opium and Narcotic Drug Act"; various aspects of the cancer problem; "The Canadian Society for the Control of Cancer"; "Medicine and the Humanities"; "Variations in Disease"; "Thrombosis and Embolism as Emergencies"; "Vision in Motor Driving"; "Ethics in Advertising"; "The March of Bacterial Chemotherapy"; "The Problem of High Blood Pressure"; "The Resuscitation of the Apparently Drowned"; "Modern Concepts in Streptococcal Epidemiology"; and "Amendments to the Food and Drugs Act".

The death of Sir Andrew Macphail, the virtual founder of our *Journal* and its first editor, took place last Fall and was suitably referred to.

Attention is called to our Convention Number, which appeared in May. This appeared in a new dress and in a form designed to stimulate interest in the Annual Meeting. The editors hope that they have succeeded in their aim.

Books by Canadian authors which have been reviewed during the year are:—"Practical Pathology, including Morbid Anatomy and Post-mortem Technique", by J. Miller and J. Davidson; "The Living Body", by C. H. Best and N. B. Taylor; "Sir Thomas Roddick", by H. E. MacDermot; "Health and Unemployment", by L. C. Marsh, A. G. Fleming and C. F. Blackler; "The Special Pathological Anatomy and Pathogenesis of the Circulatory, Respiratory, Renal and Digestive System", by H. Oertel; "Textbook of Pathology", by W. Boyd; "Classified Bibliography of Sir William Osler", by M. E. Abbott; "Clinical Diagnosis of Swellings", by C. E. Corrigan. Altogether, 255 books were received, of which 120 were reviewed and 135 merely acknowledged.

Our personal thanks are tendered to the following, whose aid has been highly appreciated:—Dr. H. E. MacDermot, the Assistant Editor and the other members of the Editorial Board; the Representatives of the Provincial Editorial Boards; Drs. T. C. Routley, Harvey Agnew, H. W. Aikens, C. C. Macklin, D. L. Thomson, J. J. Heagerty, R. L. Stehle and J. B. Collip; Dr. N. Gerald Horner, Editor of the *British Medical Journal;* the Office Staff; The Bureau of Investigation of the American Medical Association; and the Murray Printing Co., whose ready co-operation is gladly recognized.

All of which is respectfully submitted.

A. G. NICHOLLS,
Editor.

Approved.

REPORT OF THE MANAGING EDITOR

Mr. Chairman and Members of General Council:—

I beg to present the following report.

The number of *Journals* printed during the year increased by some 6,600 copies of which 2,162 were sent out in connection with the membership drive in December. The costs of producing the *Journal* were slightly lower due largely to smaller folios.

During 1938 our advertisers followed a policy of considerable caution in their expenditures, with a resultant loss of revenue to the *Journal*—but the prospects for 1939 are somewhat brighter than those reported at the last meeting as far as advertising revenue is concerned.

Our thanks are due the Sun Life Assurance Company of Canada for its continued generous support of the Hospital Service Department.

All of which is respectfully submitted.

D. SCLATER LEWIS,
Managing Editor.

Approved.

REPORT OF THE OSLER MEMORIAL COMMITTEE

Mr. Chairman and Members of General Council:—

Arrangements have been completed for the distribution, beginning this year, of Osler's "Æquanimitas and other addresses," 3rd ed., Phila., 1932, to all new Canadian medical graduates, by Charles E. Frosst & Co., as forecast in last year's report.

The (undergraduate) Osler Society of McGill will, beginning next year, hold an open meeting and reception annually on or about March 28th, the anniversary of Osler's graduation, at which an address on Osler will be given, with a demonstration, in his Library, of books and relics.

For the Association meeting in Montreal next June an "Osler Hour" has been arranged in connection with one of the general sessions, instead, but along the lines, of the Clinic proposed in the last Report.

Dr. Abbott, one of the members of the Committee, has recently published a revised edition, with index, of her classified and annotated bibliography of the writings of Osler, for which orders, at the rate of $2.25 per copy, are invited. It is hoped that some mention of this book and the original donation of which it is an outcome, may be made in the general session in connection with the "Osler Hour". The fund which has helped it financially was given by the late Mrs. R. W. Reford, Sr., in 1920, and has already helped the publication of the Osler

Memorial number of the *Association Journal* in 1920 and Dr. Abbott's "Osler Memorial Volume of the Museums Association," 1926. The remainder of the fund, together with any profits from the present publication, will be devoted to the publication of a descriptive catalogue of Osler's pathological collection, now housed under Dr. Abbott's care in the McGill Medical Museum.

The sessions of the Section of the History of Medicine at the forthcoming Association Meeting, June 21-22, are to be held, as a special exception, in the Osler Library instead of at the hotel.

All of which is respectfully submitted.

W. W. FRANCIS,
Chairman.

Approved.

REPORT OF THE COMMITTEE ON MEDICAL EDUCATION

Mr. Chairman and Members of General Council:—

Your Committee during this year has studied several problems. The first problem had to do with the education, firstly, of the medical profession and, secondly, of the public concerning so-called irregular practitioners and schools of therapy. This study was initiated as a result of a letter written by Dr. John Ferguson of Toronto to President H. J. Cody of the University of Toronto who sent a copy of the letter to The Canadian Medical Association, by whom it was referred to the Committee on Medical Education for study.

The consensus of the members of the Committee is that information regarding the methods and training of the irregular practitioners is being transmitted to medical students and the medical profession at the present time. On the other hand, the knowledge of the public concerning the nature of the preparation and education of the various cults as compared with that of the medical profession is very inadequate. In order that this lack of knowledge of the public may be remedied, your Committee begs to recommend that the Committee of the Association on publicity should make the necessary arrangements for the clarification of this condition. In this connection it is suggested that the *Journal* of the Association could be utilized more than it is at present. It could carry on a systematic campaign of enlightenment with respect to the lack of training of the cults, accounts of their doings and their attempts to gain favourable legislation, etc. Such information, if published in the *Journal*, might well filter through to the lay press and would be definitely educative.

The next problem studied by the Committee was with regard to the degrees conferred by Universities at the time of graduation in medicine, and also those given after graduation to individuals who have completed certain post-graduate courses in the different special fields of practice. The former is considered to be the particular prerogative of the universities themselves and therefore is not a matter of immediate concern to this Association. In the case of the latter, the attitude of the Association should be that of sympathetic co-operation towards the effort that is being made by The Royal College of Physicians and Surgeons of Canada to provide a recognized method for the certification of specialists.

Despite the fact that many members of the medical profession are interested in the educational developments which have been taking place in the training of future practitioners, no means are available for conveying information regarding medical education to the members of The Canadian Medical Association other than through the Report of the Committee on Medical Education to the General Council and its publication in the *Journal*. Doctors in active practice have expressed their desire, at times, to bring their views on possible improvements in the medical curriculum to the attention of those engaged in teaching students in medical schools, but no opportunity for doing this is at present available.

With a view to bringing together all those who are definitely concerned with the undergraduate and graduate education of doctors, with intern education and with licensure to practice, in addition to any others interested in these aspects of the practice of medicine, it is suggested by the Committee that a meeting of representatives of the following bodies might be called at the same time as the Annual Meeting of the Association:

The Medical Council of Canada;
The provincial licensing bodies;
The medical colleges in Canada;
The Canadian Hospital Council;
The Royal College of Physicians and Surgeons of Canada;
The provincial medical associations;
The Canadian Medical Association.

All of which is respectfully submitted.

F. J. H. CAMPBELL,
Chairman.

Approved.

REPORT OF THE DEPARTMENT OF HOSPITAL SERVICE

Mr. Chairman and Members of General Council:—

During the year it has again been our privilege to be of considerable assistance to the hospitals of Canada in meeting the many requests for the services of our Department of Hospital Service. Not only Canadian hospitals but hospitals in several other countries have availed themselves of the services of this Department.

In addition to the usual enquiries by correspondence and consultation when in the field, a number of studies relating to administration, nursing procedures, call systems for doctors, out-patient departments, and others has been conducted. A very complete study of dental services in hospitals is now being done in co-operation with the Canadian Dental Association, American Hospital Association and other bodies. During the year the Secretary was requested to write the chapter on hospitals in the current revision of the Encyclopædia Britannica. A number of radio broadcasts have been made, the most extensive being a coast to coast NBC hook-up over the American stations. The Department has co-operated also with the Faculty of Nursing of the University of Toronto in the organization and conduct of its three weeks' special course in hospital administration for nurse administrators.

INTERNSHIPS

The 1939 revision of hospitals in Canada approved for internship indicates that three hospitals have been added to the "approved" list and one removed, making a total of 51 hospitals offering 774 internships. The summary of senior internships and residencies in Canadian hospitals has been revised this year and is now ready for distribution.

INTERIM LICENSE FOR QUALIFIED INTERNS

Owing to the fact that only a small proportion of the interns in our hospitals are licensed to practise in any particular province, it has been urged repeatedly that some form of interim licensure be arranged for interns holding the Dominion Medical Council certificate or otherwise qualified. In a recent study by this Department of the intern qualifications in 12 Ontario hospitals, it was found that of the 190 graduate interns only 55 held an Ontario license; 98 had the Dominion Medical Council certificate but no Ontario license; 37 had neither. The hospital staffs and administrators strongly favoured an interim licence to qualify interns to sign papers, prescribe narcotics, etc.

It is understood that the College of Physicians and Surgeons of Ontario is endeavouring to work out a solution for this situation.

HOSPITAL CARE PLANS

Interest in this type of voluntary contributory insurance continues to grow. Several new plans have been started in Canada, notably the Manitoba Hospital Service Association with headquarters in Winnipeg. One or two, *e.g.*, Galt, Ontario, have been prepared but

not put into operation as yet. The Associated Medical Services, Inc., covering medical and certain nursing as well as hospital care, is making steady growth. Two of the provincial hospital associations, in Saskatchewan and Ontario, are seriously considering the formation of province-wide plans covering hospital care only. A city plan for Regina is also being considered. Medical support of these plans would seem to be definitely increasing. In the United States the plan in New York city has now nearly one and one-half million members and several other plans are nearing or are well over the quarter million mark. The demand for coverage for medical care from medical staffs and from the subscribers has led various medical associations to study and in several cases launch plans of this type for medical care.

Canadian Association of Medical Students and Interns

The students in seven of the medical colleges have organized the above association. Their chief objectives are to improve the health of the student and intern bodies and to promote more educational value in hospital internships. Although not instrumental in the formation of this body, our Department has been freely consulted by the students concerning factual data and with reference to their objectives and policies.

At a recent meeting it was proposed to set up a Canadian Intern Board to overcome some of the unsatisfactory features of the present haphazard methods of making appointments. A plan with some good features has been outlined and this has recently been presented to the student bodies and to the hospitals. The C.A.M.S.I. would like our Department of Hospital Service to assume direction of this plan, but our Executive Committee has deferred such action.

Joint Committee on Medical Education, Internships, Licensure and Practice

For some time past it has been evident that there are many matters of common concern and interest to various groups in the fields of medical practice, medical education, medical licensure and hospital care. At the present time we lack organized facilities for bringing these various groups together. It has been realized that there should be a standing joint committee representing these bodies, the purpose of such joint committee being to provide the means by which subjects of mutual interest or concern could be studied.

The Executive Committee of the Canadian Medical Association approved this proposal and the opinions of the following organizations were requested:

The Medical Council of Canada
The provincial licensing bodies
The medical colleges of Canada
The Canadian Hospital Council
The Royal College of Physicians and Surgeons of Canada
The provincial medical associations
The Canadian Medical Association.

Replies received were favourable to the formation of such a committee or council and a meeting is being held at this convention on Tuesday, June 20th, under the auspices of our Committee on Medical Education, upon whose recommendation this joint committee has been formed.

Canadian Hospital Council

The Canadian Hospital Council, originally sponsored by this Department, has given added opportunity to work closely with the hospitals, and the columns of its Journal, *The Canadian Hospital*, afford an unexcelled medium of disseminating authentic information on modern hospital procedure. Particularly happy are we to see the rapid progress being made in bringing about a uniform basis of accounting and statistical return across Canada.

Another Biennial Conference will be held this year in September, at which reports of study committees on hospital legislation, nursing, construction, hospital accounting and statistics, and other pertinent subjects will be discussed; a large attendance is anticipated at these active sessions.

Study of Military Hospital Equipment

The Department of National Defence, Ottawa, has requested this Department to recommend revised lists of equipment necessary in military hospitals of various sizes. A special committee, representing all parts of Canada, and made up of medical men of military and civilian experience has been formed, with the nucleus located in Toronto and surrounding area. It is the hope of the Committee that its report will be available for the Department of National Defence in the early Fall.

Code of Ethics

The Secretary of this Department has accepted the chairmanship of a committee of the American College of Hospital Administrators (a degree-conferring body) to prepare a code of ethics for hospitals and their administrative group.

International Hospital Association and American Hospital Association

Active preparations have been under way during the year for the big hospital convention to be held in Toronto in September. The combined meeting of the International Hospital Association and the American Hospital Association and six or seven associated bodies, will in all probability be the greatest hospital gathering ever held anywhere.

The Secretary of this Department has, in his official capacity as president of the American Hospital Association this year, been enabled to visit many of the larger and most up to date hospitals in the United States, and to attend a number of state association meetings. This has been an excellent opportunity of bringing to our Canadian hospitals the best of achievement by our Southern neighbours, and of passing on to them some of our own invaluable experiences.

The Department is most appreciative of the thoughtfulness of the late Mrs. A. D. Blackader in bequesting the sum of $1,200 to this Department. As the late Dr. Blackader and, subsequent to his death, the late Mrs. Blackader donated sums from time to time for the maintenance of the Blackader Library, the collection of bound volumes used as a reference library by the Department of Hospital Service, it is proposed that this gift be utilized for the maintenance of this Library.

The continued support of the work of this Department by the Sun Life Assurance Company is again gratefully acknowledged. Hospitals throughout Canada and elsewhere continue to avail themselves of the services offered and thus they and their patients are materially assisted by the generous interest of this splendid Company.

All of which is respectfully submitted.

HARVEY AGNEW,
Secretary, Department of Hospital Service.

Approved.

REPORT OF THE SPECIAL COMMITTEE ON SCHOOLS FOR LABORATORY TECHNICIANS IN CANADA AND REGISTRATION OF TECHNICIANS

Mr. Chairman and Members of General Council:—

This report is in the nature of a progress report, as there are still many details to be considered. The present undertaking of the Committee deals with two activities, considered below.

Approval of Schools for Technicians

The Committee is agreed that schools for technicians in Canada should be approved. This approval should be for two types of training—general training and specialized training, with, in some cases, a combination of the two.

Approval should be by the Canadian Medical Association acting through a Board of Pathologists.

Recognized schools for laboratory technicians, or technologists, should be located in adequately organized departments of pathology associated with hospitals having at least 300 beds, or in public or other laboratories providing comparable experience. Recognition of commercial laboratories is not recommended.

Responsibility for the courses of training in such departments should rest jointly with the hospital administration and the pathologist or biochemist in charge.

The director of the department of pathology should be a graduate in medicine who is a whole time pathologist of approved ability.

The course of training for either a general certificate or a specialist's certificate should extend over at least twelve months. Specialty training should be preceded by a twelve-months' period of general training.

General training should include technique in the following: hæmatology, bacteriology and medical zoology, histology, pathological chemistry and serology.

Special training might be in: histology, serology, bacteriology or in biochemistry.

Other provisions and requirements with respect to practical work, records, etc., are being formulated by the Committee.

REGISTRATION OF TECHNICIANS

The Committee is agreed on the necessity of setting up some means of assessing the qualifications of those seeking positions as laboratory technicians. In view of the amount of work required to set up and maintain such a registry and the formation already completed of a Canadian Society of Laboratory Technologists, the Committee has been in touch with this latter body to consider the possibility of recognizing its membership as equivalent to a registry of the standard which this Committee would consider necessary.

Negotiations to date would indicate the likelihood of effecting this arrangement. Honour matriculation for entrance is now required, the Society approves the types of training desired, and the Society is agreeable that the personnel of its Board of Examiners be subject to the approval of a Committee of Pathologists set up by the Canadian Medical Association and that the examinations also be subject to the approval of this Committee. The Society is also agreeable to the inclusion of a member of the Canadian Medical Association on its Board of Directors.

The Committee regrets that it has not been possible to complete these recommended arrangements before the time of the Annual Meeting.

All of which is respectfully submitted.

W. J. DEADMAN,
Chairman.

Approved.

REPORT OF THE MEYERS MEMORIAL COMMITTEE

Mr. Chairman and Members of General Council:—

A thesis for the Meyers Memorial Prize has been submitted to the Committee by Dr. D. G. McKerracher of the Mental Health Clinic, Brockville. This paper has been read by the Committee and, in their opinion, is worthy of the award. In order to comply with the requirements of the award, the paper is listed on the scientific program for this meeting.

Your Committee would again recommend that all the conditions governing the prize be kept before the profession by means of notices published from time to time in the *Canadian Medical Association Journal*, and circulars addressed to the Mental Hospitals of Canada.

All of which is respectfully submitted.

J. T. FOTHERINGHAM,
Chairman.

Approved.

REPORT OF THE STUDY COMMITTEE ON CANCER

Mr. Chairman and Members of General Council:—

This year the report of this Committee deals only with the progress which has been made by the doctors who compose the Canadian Medical Association in organizing a "Department of Cancer Control" within the Association and in aiding the lay citizens of Canada to organize the Canadian Society for the Control of Cancer.

While much preliminary spade work in organizing the Department of Cancer Control had been done during the late months of 1937 and the early months of 1938 it was not possible to have a full meeting of the Board of Directors until October, 1938. A meeting with one hundred per cent attendance was held in Toronto on October 31st, 1938.

The Board of Directors under the chairmanship of Dr. T. C. Routley is composed of a nucleus resident in Toronto with a corresponding member representing each province. Each corresponding member is the chairman of the cancer committee of his provincial association.

Each provincial corresponding member of the Board undertook the responsibility of organizing the provincial branch of the department in his own province and at the same time to use the personnel of its various sub-committees in aiding the formation of a Provincial Branch of the Canadian Society for the Control of Cancer in his province.

While there has not been uniform activity in all of the provinces, in some of them the provincial representatives have taken the task very seriously. They have enlisted the aid of the other members of the Provincial Cancer Committee, the officers of the Provincial Medical Association and the various District Medical Societies. These have organized rostra of medical speakers, who have addressed meetings of the lay organizations in association with laymen and women who were undertaking to organize the Provincial Branch of the Canadian Society for the Control of Cancer.

In some of the provinces the Provincial Branch of the Department of Cancer Control has already made some progress in approaching the staffs of hospitals of 100 bed minimum capacity and encouraging and aiding them to organize local cancer study committees.

As a national activity the Department of Cancer Control formed an authorship committee. It was composed of the teachers in the medical schools of Canada. This Committee prepared a handbook on cancer. It has been published and distributed without charge to all Canadian doctors, who expressed the desire to obtain a copy.

At the time the last annual report was submitted the Canadian Society for the Control of Cancer had just received letters patent from the Department of the Secretary of State for Canada. It had been operating under a Provisional Board of Directors.

Since then a Grand Council has been formed, made up of two representatives—one lay and one medical—elected by each province. This Council assembled for the first time in Toronto on November 1st, 1938. It elected a Board of Directors. A full-time executive secretary in the person of Dr. C. C. Ross has been engaged. National headquarters have been provided through the generosity of the University of Toronto, at 43 St. George Street, Toronto.

An Editorial Committee was formed. The publication of a monthly bulletin entitled "Cancer" was authorized. Three issues have already been published and distributed. A number of leaflets dealing with various phases of the cancer problem have been prepared and distributed.

On February 1st a public meeting was held in Ottawa. Addresses were delivered by His Excellency the Governor General, Professor William Boyd of Toronto, Mr. Napier Moore of Toronto and Dr. Valin of Ottawa. The addresses were broadcast through the courtesy of the Canadian Broadcasting Corporation.

At this meeting it was announced that His Majesty King George VI had graciously consented to become the Patron of the Society.

Organization of provincial branches has progressed with varying success. In some provinces progress has been satisfactory; in others circumstances have conspired to delay the work of organization. At present (April) the total membership in Canada is 3855.

To the hundreds of Canadian doctors, who have so freely given of their time and effort to aid in the task of organization, this Committee desires to express its thanks.

All of which is respectfully submitted.

J. S. McEACHERN,
Chairman.

Approved.

REPORT OF THE COMMITTEE ON MATERNAL WELFARE

Mr. Chairman and Members of General Council:—

I beg to submit the following report of the Maternal Welfare Committee for the year 1938-39.

During the year your Committee has endeavoured to assist in every way possible in making the pregnancy survey in Manitoba a success. Returns for a full year are not yet available for analysis and study. However, as this Association is keenly interested in the survey and the value of its data on Maternal Welfare likely to be forthcoming from the records of this survey, a few of the outstanding available results are submitted.

The response and co-operation of the profession increased as the year progressed and on the whole has been gratifying. The value to physicians of keeping adequate pregnancy records and the consequent necessity for care and accuracy in examinations has undoubtedly been demonstrated. The educational value of this fact alone would seem to justify the survey.

The Department of Vital Statistics for Manitoba shows that from May 1st, 1938 to April 1st, 1939, there were:—

Live births	12,035
Stillbirths	311
Total births	12,346
Births attended by physicians	10,720
Births attended by other than physicians	1,626
Maternal deaths	31
Maternal death rate 2.57% per 1,000 live births.	
Survey Pregnancy records received May 1st, 1938, to April 27th, 1939	8,123
Number of pregnancy records of maternal death received	10
Maternal deaths for which no pregnancy record	21

So far as is known in only 5 of the cases of maternal death had the patient received adequate (5-7 visits) prenatal care.

The causes of the maternal deaths were as follows:

Abortions 9; ectopic gestation 3; placenta prævia and other puerperal hæmorrhage 9; puerperal septicæmia and pyæmia 4; toxæmias of pregnancy 4; puerperal embolism 1; Cæsarean section 1.

The low maternal death rate is gratifying and impressive. Though the large percentage of deaths following abortions may be partly responsible, the fact that in 21 of the maternal deaths no pregnancy record has been received to date will be significant to those interested in maternal welfare.

In order to lessen the likelihood of error when conclusions are drawn from these pregnancy records this survey will be carried on for another year.

Although the present method for determining the maternal death rate is International in usage, it has many discrepancies and might well receive the attention of your Committee in the near future.

Manual on Obstetrical care

The sub-committee under the Chairmanship of Doctor H. B. VanWyck of Toronto has prepared an addendum for the "Outline of Obstetrical Procedure and Practice in Hospitals", which would make it more applicable in the case of small hospitals. This addendum will be added to the major portion of the study, and the entire outline of adequate provision for maternal care in hospitals will be made available shortly in bulletin form.

All of which is respectfully submitted.

J. D. McQUEEN,
Chairman.

Approved.

REPORT OF THE COMMITTEE ON PUBLIC HEALTH

Mr. Chairman and Members of General Council:—

Your Committee is pleased to report that during the past year the co-operation between the practising profession and organized medicine continued as it has in the past. This co-operation becomes more evident year by year and as a result the services which medical science has to offer to the Canadian public are made more readily available to more of Canada's citizens each year.

For many years past there has been much concern by organized medicine over the problem of tuberculosis amongst Indians; it being rightly felt that this group of our population is at present a very evident focus of infection to the white population. During the past year, through the co-operative effort of the Provincial Health Departments, the Canadian Tuberculosis Association, and the Indian Affairs Branch of the Department of Mines and Resources of the Federal Government, a more intensified drive on tuberculosis amongst Indians was begun. This was made possible through the allocation of funds for this specific purpose by the Federal Government.

The work in this connection is under the direct supervision of the Provincial Health Department in each Province, and is carried out by the Provincial organization charged with the control of tuberculosis.

The above mentioned programme relative to tuberculosis amongst Indians means that all tuberculosis control work in each Province can now be correlated, and one is safe in assuming that the next ten years will see another definite decline in the tuberculosis death rate.

It is exceedingly gratifying to your Committee to know that the last great stronghold of tuberculosis in Canada is now being scientifically attacked. The whole tuberculosis programme has received an added impetus during the past year and a very definite increase in case finding facilities is evident in every Province.

There also has been a considerable increase in beds available for the treatment of cases of this disease, particularly in the Provinces of Ontario and Alberta.

In Ontario the Government passed a new "Sanatorium Act" by which the Province assumes the full cost for indigents. This practically means that free treatment is available to everyone in the Province. Taking the four Provinces where this free treatment is now available, *i.e.*,—Saskatchewan, Alberta, Manitoba, and Ontario,—there is every facility for the proper treatment of tuberculosis to over six million people in the Dominion of Canada.

As mentioned in last year's report the Department of Pensions and National Health established, during the year 1937, four new divisions, *i.e.*,

Child and Maternal Hygiene;
Epidemiology;
Industrial Hygiene, and
Publicity and Health Education.

A Scientific Advisory Committee on Maternal Care was established in 1938. This Committee consists of five of Canada's obstetricians, and was formed to act in an advisory capacity to the division. It meets at the call of the Department of Pensions and National Health and discusses any problems which the Division of Maternal and Child Hygiene may have to present.

A second Scientific Advisory Committee was also created, *i.e.*,—a Scientific Advisory Committee on Nutrition; and the Department of Pensions and National

Health was successful in obtaining financial assistance for instituting a nutritional study at Toronto, under the auspices of the University; also one in Alberta, under the auspices of the University of Alberta.

During the past year the question of the pasteurization of milk came up for considerable discussion in the Province of Ontario; and at the 1938 Session of the Legislature of that Province amendments to "The Health Act", dealing with "pasteurization", were enacted whereby it was made possible to provide by Order-in-Council for any city, town, or municipality to have all milk used within its boundaries pasteurized. There is no doubt but that similar legislation will be ultimately brought down in many of the other Provinces.

The milk situation in British Columbia has been the subject of much controversy between the supporters of pasteurization and the raw milk dealers. Conditions in this Province are far from satisfactory and there has been one serious recent epidemic of typhoid fever in the interior of British Columbia, and cases of undulant fever continue to appear among the population in various localities. While there are many municipalities throughout Canada without pasteurization, there is not a single municipality in British Columbia where compulsory pasteurization exists. In large centres, like Vancouver, the percentage of raw milk has been slightly increased during the last few years. Such conditions call for much more rigid health regulations. As a whole, Canada continues to lag far behind the United States in the matter of milk pasteurization.

In connection with the work on the control of venereal diseases, we believe that the plans have considerably improved during the past year; certainly with the large number of articles appearing in the magazines the public attitude in connection with these diseases is rapidly changing, and it is therefore much easier to carry on a proper programme for their treatment and eradication.

British Columbia has intensified its efforts, both in public education and in the treatment and finding of cases. The Director of Venereal Disease Control is co-operating with the Vancouver City Police in controlling the one big focus of infection,—*i.e.*, prostitution.

There was created in Manitoba at the close of the year a rather unique method of controlling the disease amongst prostitutes. By an arrangement with the Winnipeg City Police and other police forces throughout the Province, all women who are apprehended for alleged infractions of "The Criminal Code" are immediately sent to the Clinic for examination. It is impossible for such a person to get out on bail or to be freed until the result of such examination is known to the Department of Health and Public Welfare. If the examination should prove that the individual is infected with gonorrhœa or syphilis she is immediately placed in detention in the Women's Provincial Gaol, situated in Portage la Prairie, for a period of three months and put under intensive treatment. If at the end of this time she is still infectious the period is extended for a further three months. This plan, to date, indicates that fifty per cent of the women picked up for infractions of The Criminal Code are found to be infected with one or other, or both, of the venereal diseases. The plan seems to be working exceedingly well and in the course of the next three months a similar procedure will be followed with respect to men apprehended for alleged infractions of The Criminal Code.

In a letter dated November 18th, 1938, your Committee was requested by the Executive, following a resolution of the Canadian Medical Association, to study during the coming year and report on the advisability or otherwise of recommending to the Dominion of Canada that a budgetary system of payment of grants be established to those national organizations engaged in health activities. In a letter from the General Secretary, dated February 23rd, 1939, your Committee was asked to make a progress report on the question of Dominion Government Grants to national organizations engaged in health activities, and your Committee reported as follows:

> "A preliminary consideration of the above mentioned subject would indicate that the payment of grants to national voluntary organizations engaged in health activities should only be made to them after very careful consideration of the following factors:
>
> 1. Their set-up, including particularly the executive personnel;
> 2. The scope of their activities—as to whether these are principally educational, or what per cent of their funds are actually devoted to health activities other than health education;
> 3. The method by which funds other than Government grants are obtained, with particular reference to the amounts obtained by subscription or canvassing.
>
> It would seem that there should be some Committee of the Federal Department, probably in the Department of Pensions and National Health, which would be responsible for reviewing of grants and advising as to their payment. This Committee should have in an advisory capacity an outside organization, possibly a Committee set up by the Canadian Medical Association, or at least established in conjunction with the organization, to which all requests for grants which appear to the Department of Pensions and National Health to be their concern may be referred for their definite consideration. Your Committee believes further study of the whole situation is required before a very definite recommendation can be made."

Further consideration of this subject leads us to the conclusion that the Canadian Medical Association should contact the Department of Pensions and National Health and discuss with them the question of grants to national voluntary health agencies. It would seem to your Committee that the Canadian Medical Association might well offer to set up an honorary advisory Committee on Grants, which the Department of Pensions and National Health could call upon for advice and assistance in deciding what national voluntary health agencies should receive grants from the Federal exchequer and what the amounts of grants should be.

All of which is respectfully submitted.

F. W. JACKSON,
Chairman.

Approved.

REPORT OF THE COMMITTEE ON NUTRITION

Mr. Chairman and Members of General Council:—

During the past year your Committee arranged for four speakers to give public addresses on Nutrition throughout Canada. During the month of September, Professor L. H. Newburgh of Ann Arbor, Michigan, gave a series of public addresses across Western Canada in conjunction with Doctor A. T. Bazin, who spoke on cancer. These addresses were given in Winnipeg, Regina, Calgary and Vancouver. Capacity audiences, reaching a maximum of 1,200 at Calgary, were present at all the meetings.

In Eastern Canada, during September and October, 1938, Sir Edward Mellanby, Secretary-General of the Medical Research Council of Great Britain, gave addresses on "Nutrition—Its Importance to the Individual and the Nation" at Montreal, Ottawa, Kingston, Toronto and London. Sir Edward also addressed the Canadian Clubs at Ottawa and at Montreal, and gave a trans-Canada broadcast originating from Ottawa. Capacity audiences were present at practically every meeting, reaching a total of 2,000 at the Toronto meeting.

Sir John Boyd Orr, Director of the Rowett Institute, Aberdeen, Scotland, gave public addresses on Nutrition during the month of April at Halifax, Montreal, Ottawa, Toronto, Hamilton and London. In addition, Sir John gave addresses to the Canadian Club at Toronto and the Hamilton Academy of Medicine, and also a trans-Canada broadcast originating from London, Ontario. The date of the Toronto address, April 25th, immediately preceded the annual meeting of the American Institute of Nutrition held in Toronto, and the members of the Council of this body arranged to be in Toronto on the 25th and attended Sir John's public address at Convocation Hall. The number of people in attendance was approximately 2,200, with several hundreds being turned away.

Arrangements have been completed for Professor Edward Provan Cathcart, of Glasgow, Scotland, to give

a public address on Nutrition in Montreal on Monday, June 19th, at the time of the Canadian Medical Association meeting. Professor Cathcart will also appear on the scientific programme of the annual meeting, and will speak at the annual meeting of the Canadian Public Health Association.

The series of articles on Nutrition currently appearing in the *Canadian Medical Association Journal* will be completed with the August, 1939, number of the *Journal*. In accord with the authorization at the October meeting of the Executive Committee, these articles will be reprinted in book form and distributed to every physician in Canada.

The popular booklet, "What to Eat to be Healthy," issued under the joint auspices of the Canadian Medical Association and the Canadian Life Insurance Officers Association has now run through two editions, with a total distribution to the people of Canada of one million copies. This booklet has been translated into French and 55,000 copies have been issued in this language.

A series of eight coloured posters on "What to Eat to be Healthy" has been prepared specially for school children, and through the cooperation of the Canadian Life Insurance Officers Association and the Department of Education of the Province of Ontario will be distributed to a limited number of schools in Ontario to ascertain their value in the school curriculum. The initial printing involves the distribution of 40,000 of these posters.

In its programme to draw to the attention of the Canadian people the importance of proper nutrition and its relation to health, your Committee, during the past two years, has collaborated with the Canadian Life Insurance Officers Association. The amount of money expended during the past two years in this effort has exceeded $35,000. The Committee is deeply indebted to the Canadian Life Insurance Officers Association for this tangible evidence of their interest in the health of the people, and it is recommended to the General Council by your Committee that the thanks of this Association be extended to the Canadian Life Insurance Officers Association.

All of which is respectfully submitted.

FREDERICK F. TISDALL,
Chairman.

Approved.

REPORT OF THE COMMITTEE ON CONSTITUTION AND BY-LAWS

Mr. Chairman and Members of General Council:—

Your Committee on Constitution and By-Laws has met at various times during the past year to consider matters brought before it by the Executive Committee and to take such action upon these and other matters as seemed necessary. We now beg to report as follows.

(1) Correspondence with New Brunswick Medical Society and Manitoba Medical Association Relative to Federation

At the October meeting of the Executive Committee a resolution was adopted which instructed the Chairman of the Committee on Constitution and By-Laws to enter into correspondence with the Executive Committee of the New Brunswick Medical Society and the Chairman of the Committee on Federation of the Manitoba Medical Association relative to Federation and to discuss the differences which are apparent. This has been done.

NEW BRUNSWICK

I am in receipt of a letter from Dr. Everett Gray, President of the New Brunswick Medical Society which culminates a correspondence carried out during the past six months. He has resubmitted the question by letter to his Executive Committee. I quote the essential sentence of his letter. At this stage, of course, it can only be interpreted as Dr. Gray's personal opinion. "I feel our New Brunswick Medical Society Executive will recommend unanimously that we join the Canadian Medical Association as a Division at our annual meeting in August without change in Constitution and By-Laws of the Canadian Medical Association."

MANITOBA

Correspondence with Dr. McKenty, Chairman of the Committee on Federation and Dr. MacCharles, Secretary of the Executive Committee of the Manitoba Medical Association is still being carried out. In addition I have taken advantage of the opportunity provided by the meeting of the Executive Committee of the Canadian Medical Association in Toronto in March to have a personal conversation with Dr. Trainor. Much has been accomplished to find a common ground for discussion and I am of the opinion that as we are in agreement on the principles involved it is quite possible for us to solve the details over which some difference of opinion is expressed.

(2) Dr. Bazin drew attention to a certain ambiguity in the wording of Chapter 8, Section IV of the By-Laws. Recommendation for revision to correct this is included in the revised consolidated Constitution and By-Laws attached. It has already been submitted to and approved by the Executive Committee.

(3) Senior Members

The Executive Committee meeting in October drew attention to the fact that the manner of the election of senior members as provided in Chapter 2, Section 3 of the By-Laws precludes the certainty of their being present at the annual meeting at which they are elected in order that they may then formally receive their honour. This has been overcome by the provision that such members be elected by the Executive Committee and is incorporated in the revised consolidated Constitution and By-Laws attached.

(4) Head Offices of the C.M.A.

The Executive Committee requested that a by-law be drafted stating that the offices of the Association are at Toronto and Montreal. This has been done and is included in the revised consolidated Constitution and By-Laws attached. (Chapter 13).

(5) Approval of Constitutions of Divisions

Chapter 1 of the By-Laws provides for the formation of Provincial Divisions and amongst other things indicates that the Constitutions of the Divisions shall be revised where necessary to bring them into conformity with that of the Canadian Medical Association. The Divisions of Prince Edward Island, Nova Scotia, Quebec, Ontario, Saskatchewan and British Columbia have accordingly submitted their constitutions to this Committee for examination. They have all been examined and approved.

(6) Consolidated Constitution

Two constitutions are now of necessity in use by the Canadian Medical Association; one relative to Divisions and one relative to Branch Associations. The Executive Committee requested that these be consolidated into one if feasible. After some discussion this was undertaken and is now presented. It includes in addition certain revisions necessary to implement the various instructions of the Executive Committee mentioned above and also certain other revisions which your Committee considered wise. The most important of these concerns the constitution of General Council (Article IX) and the transfer of certain committees from the class of special committees to the class of standing committees. (Article X).

In connection with the question of Committees and in addition to the minor revisions we are recommending in the revised Consolidated Constitution and By-Laws your Committee recommends that the Executive Committee be instructed by General Council to consolidate the Committees on Hospital Interns and Laboratory Technicians with the Committee on Hospital Service and the Myers Memorial Committee and the Osler Memorial Committee with the Committee on Awards, Orations and Scholarships.

The proposed revisions and consolidation of the Constitution follow.

PROPOSED CONSOLIDATED CONSTITUTION FOR THE CANADIAN MEDICAL ASSOCIATION

WITH WHICH IS PRINTED, FOR PURPOSES OF REFERENCE, THE EXISTING CONSTIUTIONS FOR BRANCH ASSOCIATIONS AND DIVISIONS. THESE HAVE BEEN FUSED AND INCORPORATED IN THE PROPOSED CONSOLIDATED CONSTITUTION.

Note:—Those sections of the existing Constitutions which could be utilized in the Consolidated Constitution without change are unmarked. Where change has been necessary the paragraph is marked thus *.

CONSTITUTION FOR BRANCHES

ARTICLE I.—TITLE

This Association shall be known as The Canadian Medical Association, and, when the French language is used, it shall be known as ''L'Association Médicale Canadienne''.

ARTICLE II.—OBJECTS

1. The promotion of health and the prevention of disease.
2. The improvement of medical services however rendered.
3. The maintenance of the integrity and honour of the medical profession.
4. The performance of such other lawful things as are incidental or conducive to the welfare of the public and of the medical and allied professions.

ARTICLE III.—ETHICS

The Code of Ethics of The Association shall be such as may be adopted by The Association from time to time. A copy shall be supplied to all members of The Association.

ARTICLE IV.—MEMBERSHIP

The Association shall be composed of ordinary members, members-at-large, senior, non-resident and honorary members, elected by the method set forth in the By-Laws.

ARTICLE V.—BRANCH ASSOCIATIONS

Each Provincial Medical Association is recognized as a Branch Association and shall be represented on the General Council and on the Executive Committee of The Canadian Medical Association.

Any Branch, if it so desire, may change its relationship to The Canadian Medical Association and become a Division. It shall then be known as The Canadian Medical Association, ... (name of Province) Division. All of its members shall be members of The Canadian Medical Association and shall be entitled to all the rights and privileges of membership.

CONSTITUTION FOR DIVISIONS

ARTICLE I.—TITLE

This Association shall be known as The Canadian Medical Association, and when the French language is used, it shall be known as ''L'Association Médicale Canadienne''.

ARTICLE II.—OBJECTS

1. The promotion of health and the prevention of disease.
2. The improvement of medical services however rendered.
3. The maintenance of the integrity and honour of the medical profession.
4. The performance of such other lawful things as are incidental or conducive to the welfare of the public and of the medical and allied professions.

ARTICLE III.—ETHICS

The Code of Ethics of The Association (see Appendix) shall be such as may be adopted by The Association from time to time. A copy shall be supplied to each member of The Association.

ARTICLE IV.—MEMBERSHIP

The Association shall be composed of ordinary members, members-at-large, senior, non-resident and honorary members, elected by the method set forth in the By-Laws.

ARTICLE V.—BRANCH ASSOCIATIONS

Each Provincial Medical Association, or the body representing organized medicine in a province and enjoying all the rights and privileges of a medical association, may be recognized as a Branch Association, but any Branch Association, if it so desire, may change its relationship to The Canadian Medical Association and become a Division by the method set forth in the By-Laws. It shall then be known as The Canadian Medical Association (name of Province) Division.

PROPOSED CONSOLIDATED CONSTITUTION

ARTICLE I.—TITLE

This Association shall be known as The Canadian Medical Association, and when the French language is used, it shall be known as ''L'Association Médicale Canadienne''.

ARTICLE II.—OBJECTS

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2. The improvement of medical services however rendered.
3. The maintenance of the integrity and honour of the medical profession.
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The Code of Ethics of The Association (see Appendix) shall be such as may be adopted by The Association from time to time. A copy shall be supplied to each member of The Association.

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CONSTITUTION FOR BRANCHES

ARTICLE VI.—AFFILIATED SOCIETIES

Any nationally or internationally organized medical, scientific, or sociological body may, subject to the approval of the General Council, become affiliated with The Canadian Medical Association. Affiliation shall be understood to imply the establishment of a friendly relationship with the affiliated organization. There shall be no obligation on the part of either party to the affiliation to sponsor policies or movements on the part of the other.

ARTICLE VII.—MEETINGS

The meetings of The Association shall be held in whole or in part on such occasions as may be provided for in the By-Laws.

ARTICLE VIII.—OFFICERS

(*a*) The Patron.

(*b*) The elective officers of The Association shall be a President, a President-Elect, a Chairman of the General Council, and an Honorary-Treasurer.

(*c*) The appointive officers of The Association shall be a General Secretary and such other officers as may be appointed by the Executive Committee.

ARTICLE IX.—THE GENERAL COUNCIL

The General Council shall consist of:—

(*a*) The officers of The Association.

(*b*) The President and Secretary or Joint Secretaries of the Provincial Branches.

(*c*) Delegates elected by the Provincial Branches.

Each Branch Association shall be entitled to elect five delegates to serve on the General Council for its membership in The Canadian Medical Association of fifty or less; one additional delegate for its membership from fifty-one to one hundred; another delegate for its membership from 101 to 300; and, thereafter, one delegate for every 300 members above 300.

(*d*) Chairmen and Secretaries of Committees of The Association.

(*e*) Chairmen and Secretaries of Sections of The Association.

(*f*) Past-Presidents of The Association.

(*g*) Two representatives of the Department of Pensions and National Health.

CONSTITUTION FOR DIVISIONS

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ARTICLE VIII.—OFFICERS

(*a*) The Patron.

(*b*) The elective officers of The Association shall be a President, a President-Elect, a Chairman of the General Council, and an Honorary-Treasurer.

(*c*) The appointive officers of The Association shall be a General Secretary and such other officers as may be appointed by the Executive Committee. The appointive officers shall have no voting power.

ARTICLE IX.—THE GENERAL COUNCIL

In so far as it relates to Divisions, the General Council shall consist of:—

(*a*) The officers of The Association.

(*b*) The President and Secretary of each Division.

(*c*) Delegates elected by Divisions including members of the Nominating Committee.

Each Division shall be entitled to elect five delegates to serve on the General Council for its membership in The Canadian Medical Association of fifty or less; one additional delegate for its membership from fifty-one to one hundred; one additional delegate for its membership from 101 to 300; and thereafter one delegate for every 300 above 300. One divisional representative on Council may be named by the Division as its nominee to the Nominating Committee of The Association.

(*d*) Chairmen and Secretaries of Committees of The Association.

(*e*) Chairmen and Secretaries of Sections of The Association.

(*f*) Past-Presidents of The Association.

(*g*) Two representatives of the Department of Pensions and National Health.

PROPOSED CONSOLIDATED CONSTITUTION

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(*b*) The elective officers of The Association shall be a President, a President-Elect, a Chairman of the General Council, and an Honorary-Treasurer.

(*c*) The appointive officers of The Association shall be a General Secretary and such other officers as may be appointed by the Executive Committee. The appointive officers shall have no voting power.

*ARTICLE IX.—THE GENERAL COUNCIL

*The General Council shall consist of:—

*(*a*) The officers of The Association.

*(*b*) The President and Secretary or Joint Secretaries of each Branch Association or Division.

*(*c*) Delegates elected by Branch Associations and Divisions amongst whom shall be included the members designated by Divisions for the Nominating Committee and The Executive Committee.

*Each Branch Association or Division shall be entitled to elect five delegates to serve on the General Council for its membership in The Canadian Medical Association of fifty or less; one additional delegate for its membership from fifty-one to one hundred; one additional delegate for its membership from 101 to 300; and thereafter one delegate for every 300 above 300. One of its representatives on Council may be named by a Division as its nominee to the Nominating Committee of the Association.

* (*d*) The Chairmen of the Standing Committees of The Association.

(*e*) Past-Presidents of The Association.

(*f*) Two representatives of the Department of Pensions and National Health, who are members of The Canadian Medical Association, one of whom shall be the Deputy Minister of Pensions and National Health.

CONSTITUTION FOR BRANCHES

ARTICLE X.—COMMITTEES

The Committees shall be (*a*) Standing; (*b*) Special.

(*a*) The Executive Committee shall be elected by the General Council; the other standing committees shall be appointed by the Executive Committee.

The standing committees are as follows:—

1. The Executive Committee.
2. The Committee on Legislation.
3. The Committee on Medical Education.
4. The Post-Graduate Committee.
5. The Committee on Program.
6. The Committee on Constitution and By-Laws.
7. The Committee on Archives.
8. The Committee on Public Health.
9. The Committee on Ethics and Credentials.
10. The Committee on Economics.
11. The Committee on Pharmacy.
12. The Committee on Hospital Service.
13. The Cancer Committee.

(*b*) Special Committees may be appointed by—

(i) The President.
(ii) The General Council.
(iii) The Executive Committee.
(iv) The Chairman of the General Council.

ARTICLE XI.—FUNDS

Funds for the purpose of The Association shall be raised in such manner as may be determined by the General Council.

ARTICLE XII.—THE ASSOCIATION YEAR

The Association year shall be the calendar year.

ARTICLE XIII.—AMENDMENTS

1. Notice of Motion by individual members or others to amend the Constitution must be placed in the hands of the General Secretary six months before the date of the annual meeting.

2. Amendments may be proposed by the General Council, the Executive Committee or the Committee on Constitution and By-Laws, without notice of motion, but the proposed amendments shall be published in the *Journal* in two issues preceding the annual meeting.

3. The Constitution shall be amended by a two-thirds vote of the members of the General Council in session present and voting.

CONSTITUTION FOR DIVISIONS

ARTICLE X.—COMMITTEES

The Committees shall be (*a*) Standing; (*b*) Special.

(*a*) The Executive Committee shall be elected by the General Council; the other standing committees shall be appointed by the Executive Committee.

The standing committees are as follows:—

1. The Executive Committee.
2. The Committee on Legislation.
3. The Committee on Medical Education
4. The Post-Graduate Committee.
5. The Central Program Committee.
6. The Committee on Constitution and By-Laws.
7. The Committee on Archives.
8. The Committee on Public Health.
9. The Committee on Ethics and Credentials.
10. The Committee on Economics.
11. The Committee on Pharmacy.
12. The Committee on Hospital Service.
13. The Cancer Committee.

(*b*) Special Committees may be appointed by—

(i) The President.
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(iii) The Executive Committee.
(iv) The Chairman of the General Council.

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PROPOSED CONSOLIDATED CONSTITUTION

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3. The Committee on Medical Education
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5. The Central Program Committee.
6. The Committee on Constitution and By-Laws.
7. The Committee on Archives.
8. The Committee on Public Health.
9. The Committee on Ethics and Credentials.
10. The Committee on Economics.
11. The Committee on Pharmacy.
12. The Committee on Hospital Service.
13. The Cancer Committee.
*14. The Committee on Maternal Welfare.
*15. The Committee on Nutrition.

(*b*) Special Committees may be appointed by—

(i) The President.
(ii) The General Council.
(iii) The Executive Committee.
(iv) The Chairman of the General Council.

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3. The Constitution shall be amended by a two-thirds vote of the members of the General Council in session present and voting.

CONSTITUTION FOR BRANCHES

BY-LAWS

CHAPTER I.—MEMBERSHIP

Section 1—Ordinary Members

Any member in good standing in a Branch Association shall be automatically an *ordinary member* of The Canadian Medical Association provided that he (she) pays the annual fee as levied by the General Council.

Section 2—Members-at-Large

Any graduate in medicine residing in any province of Canada, who is not a member of a Branch Association shall be accepted as a member of The Canadian Medical Association on written approval presented to the General Secretary from the Executive body of the Branch Association in the province in which he (she) resides. He (she) shall be liable for the annual fee. Such members shall be designated *Members-at-Large.*

CONSTITUTION FOR DIVISIONS

ARTICLE XIV.—PROVINCIAL AUTONOMY

No provision of the Constitution or By-Laws herein set forth shall interfere with the status of a Division as a provincial organization. As a provincial body it shall have complete control of its own affairs, and if it choose, may retain its present name, as well as being known as Canadian Medical Association (name of Province) Division.

BY-LAWS

CHAPTER I.—DIVISIONS

A Branch of The Canadian Medical Association may become a Division as outlined in Chapter V of the Constitution and enjoy all the rights and privileges of a Division in the following manner:—

1. By intimating to The Canadian Medical Association in writing that it desires to become a Division.
2. By agreeing to amend, where necessary, its Constitution and By-Laws to place them in harmony with the Constitution and By-Laws of this Association.
3. By agreeing to collect from all of its Divisional Members who desire to be members of The Canadian Medical Association such annual fee as may from time to time be set for membership and remit same to this Association.
4. By agreeing to take such steps as seem proper to the Division to increase membership in The Association.

CHAPTER II.—MEMBERSHIP

Section 1—Ordinary Members

Every Member in good standing in a Branch Association or a Division shall be automatically an ordinary Member of The Canadian Medical Association on payment of the annual fee as levied by the General Council.

Section 2—Members-at-Large

Any graduate in Medicine, residing in Canada, who is not a Member of a Branch Association or of a Division may be accepted as a Member-at-large of The Canadian Medical Association provided that, with his application, a certificate of approval from the executive body of the Branch Association or Division in the Province in which the applicant resides be furnished to the General Secretary. In the case of an applicant residing in Canada in a territory beyond the jurisdiction of a Branch Association or of a Division, the application must be endorsed by two Members of The Canadian Medical Association. Such Members shall be designated "Members-at-Large" and shall pay the annual fee as levied by the General Council.

PROPOSED CONSOLIDATED CONSTITUTION

*ARTICLE XIV.—PROVINCIAL AUTONOMY

No provision of the Constitution or By-Laws herein set forth shall interfere with the status of a Branch Association or Division as a provincial organization. As a provincial body it shall have complete control of its own affairs. In the case of a Division, if it choose, it may retain its present name, as well as being known as Canadian Medical Association (name of Province) Division.

BY-LAWS

*CHAPTER I.—DIVISIONS

A Branch Association may become a Division as outlined in Article V of the Constitution and enjoy all the rights and privileges of a Division in the following manner:—

1. By intimating to The Canadian Medical Association in writing that it desires to become a Division.
2. By agreeing to amend where necessary, its Constitution and By-Laws to place them in harmony with the Constitution and By-Laws of this Association.
3. By agreeing to collect from all of its Divisional Members who desire to be members of The Canadian Medical Association such annual fee as may from time to time be set for membership and remit same to this Association.
4. By agreeing to take such steps as seem proper to the Division to increase membership in The Association.

*CHAPTER II.—MEMBERSHIP

Section 1—Ordinary Members

Every Member in good standing in a Branch Association or a Division shall be automatically an ordinary Member of the Canadian Medical Association on payment of the annual fee as levied by the General Council.

**Section 2—Members-at-Large*

Any graduate in Medicine residing in Canada, who is not a Member of a Branch Association or of a Division may be accepted as a Member of The Canadian Medical Association provided that, with his application, a certificate of approval from the executive body of the Branch Association or Division in the Province in which the applicant resides be furnished to the General Secretary. In the case of an applicant residing in Canada in a territory beyond the jurisdiction of a Branch Association or of a Division, the application must be endorsed by two Members of The Canadian Medical Association. Such Members shall be designated "Members-at-Large" and shall pay the annual fee as levied by the General Council.

CONSTITUTION FOR BRANCHES

Section 3—Senior Members

Any member of The Association in good standing who has attained the age of seventy years is eligible to be nominated for senior membership by any ordinary member of The Association, but may be elected only by the unanimous approval of the members of the General Council in session present and voting. Not more than ten such senior members may be elected in any one year. Senior members shall enjoy all the rights and privileges of The Association, but shall not be required to pay any annual fee.

Section 4—Non-Resident Members

Non-Resident Members may be elected by the Executive Committee from regularly qualified practitioners residing outside of Canada. They shall be required to pay not more than seventy-five per cent of the annual fee.

Section 5—Honorary Members

Honorary Members may be nominated by any Member of The Association and shall be elected only by unanimous vote of the General Council in session present and voting. Not more than five Honorary Members may be elected in any one year and at no time shall the list of living Honorary Members exceed twenty-five. Honorary Members shall enjoy all the rights and privileges of The Association, but shall not be required to pay an annual fee.

Section 6—Discipline of Members

Any Member failing to conform to the Constitution and By-Laws and Code of Ethics shall be liable to censure, suspension or expulsion.

(*a*) Any member whose annual fee has not been paid on or before the 31st day of March of the current year, may, without prejudice to his liability to The Association, be suspended from all privileges of membership.

(*b*) Any Member who has been found guilty of unprofessional conduct may, upon representation of the facts to the General Council, be censured, suspended or expelled from The Canadian Medical Association.

Section 7—Restoration to Membership

A Member, suspended or expelled, shall not be restored to membership until all arrears of fees have been paid or such requirements, as may be determined by the General Council or the Executive Committee, have been met.

CONSTITUTION FOR DIVISIONS

Section 3—Senior Members

Any Member of The Association in good standing for the immediately preceding ten-year period who has attained the age of seventy years is eligible to be nominated for Senior Membership by any ordinary member of The Association, but may be elected only by the unanimous approval of the members of the General Council in session present and voting. Not more than ten such Senior Members may be elected in any one year. Senior Members shall enjoy all the rights and privileges of The Association, but shall not be required to pay any annual fee.

Section 4—Non-Resident Members

Non-Resident Members may be elected by the Executive Committee from regularly qualified practitioners residing outside of Canada. They shall be required to pay not more than seventy-five per cent of the annual fee for Members-at-Large.

Section 5—Honorary Members

Honorary Members may be nominated by any Member of The Association and shall be elected only by a unanimous vote of the General Council in session present and voting. Not more than five Honorary Members may be elected in any one year and at no time shall the list of living Honorary Members exceed twenty-five. Honorary Members shall enjoy all the rights and privileges of The Association, but shall not be required to pay any annual fee.

Section 6—Discipline of Members

Any Member failing to conform to the Constitution and By-Laws and/or Code of Ethics (see Appendix) shall be liable to censure, suspension or expulsion.

(*a*) Any Member whose annual fee is directly payable to The Canadian Medical Association and whose annual fee has not been paid on or before the 31st day of March of the current year, may, without prejudice to his liability to The Association, be suspended from all privileges of membership.

(*b*) Any Member who has been found guilty of unprofessional conduct may, upon representation of the facts to the General Council, be censured, suspended or expelled from The Canadian Medical Association.

Section 7—Restoration to Membership

A Member, suspended or expelled, shall not be restored to membership until all arrears of fees (if directly payable to The Canadian Medical Association) have been paid, or until such requirements as may be determined by the General Council or the Executive Committee have been met.

PROPOSED CONSOLIDATED CONSTITUTION

**Section 3—Senior Members*

Any Member of The Association in good standing for the immediately preceding ten-year period who has attained the age of seventy years is eligible to be nominated for Senior Membership by an ordinary member of The Association. He may be elected only by the unanimous approval of the members of the Executive Committee in session present and voting. Not more than ten such Senior Members may be elected in any one year. Senior Members shall enjoy all the rights and privileges of The Association, but shall not be required to pay any annual fee.

Section 4—Non-Resident Members

Non-Resident Members may be elected by the Executive Committee from regularly qualified practitioners residing outside of Canada. They shall be required to pay not more than seventy-five per cent of the annual fee as levied by General Council.

Section 5—Honorary Members

Honorary Members may be nominated by any Member of The Association and shall be elected only by a unanimous vote of the Executive Committee or the General Council in session present and voting. Not more than five Honorary Members may be elected in any one year and at no time shall the list of living Honorary Members exceed twenty-five. Honorary Members shall enjoy all the rights and privileges of The Association, but shall not be required to pay any annual fee.

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A Member, suspended or expelled, shall not be restored to membership until all arrears of fees (if directly payable to The Canadian Medical Association) have been paid, or until such requirements as may be determined by the General Council or the Executive Committee have been met.

CONSTITUTION FOR BRANCHES

Section 8—Resignation from Membership.

Membership in The Association shall automatically cease only on suspension, expulsion, or death. Resignation may be effected by giving notice in writing to the General Secretary one month before the next annual fee is due.

Section 9—Registration at Meetings

No Member shall take part in the proceedings of The Association or in the proceedings of any of the sections thereof until he (she) has properly registered and paid his (her) annual fee.

CHAPTER II.—GUESTS AND VISITORS

Section 1—Visitors from outside of Canada

Medical practitioners and other men of science residing outside of Canada may attend the annual meeting as guests of the President or of the General Council, or as visitors when vouched for by the General Secretary. They shall register with the General Secretary without payment of fee and may, after proper introduction, be allowed to participate in discussions.

Section 2—Medical Students attending Meetings

Any hospital intern or medical student, when properly vouched for, may be admitted as a visitor to the scientific meetings but he shall not be allowed to take part in any of the proceedings unless he has been specially invited by the Committee on Program to present a communication.

Section 3—Delegates from Affiliated Societies at Scientific Meetings.

Two delegates from each affiliated society, one of whom shall be a member of this Association, may attend the scientific meetings.

Section 4—Delegates from Affiliated Societies at Meetings of General Council

Two delegates from each affiliated society, provided one delegate is a member of this Association, may be invited by the Executive Committee to attend meetings of the General Council. They may, at the request of the Chairman, take part in the deliberations but shall have no voting power.

CONSTITUTION FOR DIVISIONS

Section 8—Resignation from Membership

Membership in The Association shall automatically cease only on suspension, expulsion or death. Resignation may be effected by giving notice in writing to the Secretary of the Division not less than one month before the beginning of the calendar year; or in the case of a Member-at-Large by giving notice directly to the General Secretary of The Canadian Medical Association one month before the next annual fee is due.

Section 9—Registration at Meetings

No Member shall take part in the proceedings of The Canadian Medical Association or in the proceedings of any of the Sections thereof or attend any part of the meeting until he has properly registered. Only Members and invited guests are eligible to register and attend an annual meeting.

CHAPTER III.—GUESTS AND VISITORS

Section 1—Visitors from outside of Canada

Medical practitioners and other men of science residing outside of Canada may attend the annual meeting as guests of the President or of the General Council, or as visitors when vouched for by the General Secretary. They shall register with the General Secretary without payment of fee and may, after proper introduction, be allowed to participate in discussions.

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Two delegates from each affiliated society, one only of whom is required to be a Member of this Association, may attend the scientific meetings.

Section 4—Delegates from Affiliated Societies at Meetings of General Council

Two delegates from each affiliated society, provided one delegate is a Member of this Association, may be invited by the Executive Committee to attend meetings of the General Council. They may, at the request of the Chairman, take part in the deliberations but shall have no voting power.

PROPOSED CONSOLIDATED CONSTITUTION

**Section 8—Resignation from Membership*

Membership in The Association shall automatically cease only on suspension, expulsion or death. Resignation may be effected (1) in the case of a member of a Division by giving notice to the Secretary of the Division not less than one month before the beginning of the calendar year; (2) in the case of a member of a Branch Association or in the case of a Member-at-Large by giving notice directly to the General Secretary of The Canadian Medical Association one month before the next annual fee is due.

**Section 9—Registration at Meetings*

No Member shall take part in the proceedings of The Canadian Medical Association or in the proceedings of any of the Sections thereof or attend any part of the meeting until he has properly registered. Only Members and invited guests are eligible to register and attend an annual meeting.

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Two delegates from each affiliated society, provided one delegate is a Member of this Association, may be invited by the Executive Committee to attend meetings of the General Council. They may, at the request of the Chairman, take part in the deliberations but shall have no voting power.

CONSTITUTION FOR BRANCHES

CHAPTER III.—ANNUAL MEETINGS

Section 1—Time and Place of Meetings

The time and place of meetings shall be decided by the General Council, and shall be announced as early as possible.

Section 2—Arrangements for Annual Meetings

When The Canadian Medical Association meets in any province where there is a Branch Association, the meeting shall be held in conjunction with that of the Branch Association. The local arrangements shall be under the direction of the Executive Committee of The Canadian Medical Association, which may enlist the assistance of the Branch Association. The Canadian Medical Association assumes full control of the proceedings of the meeting and of all financial obligations save entertainment.

Section 3—Type of Program

The program of the meeting may consist of business sessions, general and sectional scientific sessions.

Section 4—Presiding Officer

The President or some person designated by him shall preside at all general meetings.

Section 5—Rules of Order

The Rules of Order which govern the proceedings of the House of Commons of Canada shall be the guide for conducting all meetings of The Association.

CHAPTER IV.—MEETINGS OF SECTIONS

Section 1—Sectional Scientific Sessions

The Executive Committee shall determine what scientific Sections shall hold sessions at any annual meeting.

Section 2—Appointment of Sectional Officers

The Chairman and Secretary for each scientific Section shall be appointed by the Executive Committee.

Section 3—Presiding Officers at Meetings of Sections

The Chairman of the Section, or some one designated by him, shall preside at all meetings of the Section.

Section 4—Duties of Secretaries of Sections

The Secretary of the Section shall keep a correct record of the transactions and shall transmit it to the General Secretary for insertion in a Minute Book provided for the purpose.

CONSTITUTION FOR DIVISIONS

CHAPTER IV.—ANNUAL MEETINGS

Section 1—Time and Place of Meetings

The time and place of meetings shall be decided by the General Council or the Executive Committee, and shall be announced as early as possible.

Section 2—Arrangements for Annual Meetings

When The Canadian Medical Association meets in any province where there is a Division, the meeting of that Division for that year shall be for business purposes only. The local arrangements shall be under the direction of the Executive Committee of The Canadian Medical Association, which may enlist the assistance of the Division or one of its component societies. The Canadian Medical Association assumes full control of the proceedings of the meeting and of all financial obligations save entertainment.

Section 3—Type of Program

The program of the meeting may consist of business sessions, general and sectional scientific sessions, and any other sessions which may be decided upon by the Executive Committee.

Section 4—Presiding Officer

The President or some person designated by him shall preside at all general meetings.

Section 5—Rules of Order

The Rules of Order which govern the proceedings of the House of Commons of Canada shall be the guide for conducting all meetings of The Association.

CHAPTER V.—MEETINGS OF SECTIONS

Section 1—Sectional Scientific Sessions

The Executive Committee shall determine what scientific Sections shall hold sessions at any annual meeting.

Section 2—Appointment of Sectional Officers

The Chairman and Secretary for each scientific Section shall be appointed by the Executive Committee.

Section 3—Presiding Officers at Meetings of Sections

The Chairman of the Section, or some one designated by him, shall preside at all meetings of the Section.

Section 4—Duties of Secretaries of Sections

The Secretary of the Section shall keep a correct record of the transactions and shall transmit it to the General Secretary for insertion in the Minute Book provided for the purpose.

PROPOSED CONSOLIDATED CONSTITUTION

CHAPTER IV.—ANNUAL MEETINGS

**Section 1—Time and Place of Meetings*

The time and place of meetings shall be decided by the General Council or the Executive Committee, and shall be announced as early as possible.

**Section 2—Arrangements for Annual Meetings*

When The Canadian Medical Association meets in any province where there is a Branch Association or Division, the meeting of that Branch Association or Division for that year shall be for business purposes only. The local arrangements shall be under the direction of the Executive Committee of The Canadian Medical Association, which may enlist the assistance of the Branch Association or Division or one of its component societies. The Canadian Medical Association assumes full control of the proceedings of the meeting and of all financial obligations save entertainment.

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The program of the meeting may consist of business sessions, general and sectional scientific sessions, and any other sessions which may be decided upon by the Executive Committee.

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The President or some person designated by him shall preside at all general meetings.

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The Rules of Order which govern the proceedings of the House of Commons of Canada shall be the guide for conducting all meetings of The Association.

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The Executive Committee shall determine what scientific Sections shall hold sessions at any annual meeting.

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The Chairman and Secretary for each scientific Section shall be appointed by the Executive Committee.

Section 3—Presiding Officers at Meetings of Sections

The Chairman of the Section, or some one designated by him, shall preside at all meetings of the Section.

Section 4—Duties of Secretaries of Sections

The Secretary of the Section shall keep a correct record of the transactions and shall transmit it to the General Secretary for insertion in the Minute Book provided for the purpose.

CONSTITUTION FOR BRANCHES

CHAPTER V.—OFFICERS AND EXECUTIVE COMMITTEE

Section 1—Appointment of Nominating Committee

The General Council, at the first session of the annual meeting, shall elect by ballot from among its members present a Nominating Committee of fifteen members not including the President and General Secretary who shall be respectively *ex officio* Chairman and *ex officio* Secretary of the Committee.

Candidates for election to the Nominating Committee shall be named from the floor, and the list shall include the names of one or more members of each Branch Association if represented at this session.

The candidate in each province holding the highest vote of the candidates from that province shall be declared elected. The remaining members shall be declared elected by majority vote.

The election shall be decided on a single ballot. The Chairman of the General Council shall, if necessary, give the casting vote or votes.

Section 2—Duties of Nominating Committee

The Nominating Committee shall meet on the day of its election and submit to a later session of the General Council:—

1. Nomination of the following officers of The Association: a President-Elect, a Chairman of the General Council and an Honorary-Treasurer.

2. Nomination of an Executive Committee which, in addition to those who are members *ex officio* (See Chapter VII, Section 4), shall consist of thirteen members geographically distributed as follows: three shall be resident in each of the two provinces in which the offices of The Association are located and one in each of the other provinces.

3. *Rules of Procedure.*—The Committee shall be called to order by the President as Chairman *ex officio* of the Committee. In the absence of the President, the General Secretary shall convene the Committee and request the Committee to select, by open vote, the Chairman. The Committee shall then proceed to carry out its duties by open vote. In case of a tie vote, the Chairman shall have the casting vote in addition to the vote to which he is entitled as a member of the Committee. When called for, the report of the Committee

CONSTITUTION FOR DIVISIONS

CHAPTER VI.—OFFICERS AND EXECUTIVE COMMITTEE

Section 1—Appointment of Nominating Committee

(*a*) The General Council at its first session at the time of the annual meeting shall elect by ballot from among its members present a Nominating Committee of NINE not including the President who shall be *ex officio* a member of the Committee and Chairman thereof.

(*b*) Each Division in The Association is entitled to nominate one member to the Nominating Committee. Provided this nomination be made in writing to the General Secretary prior to the annual meeting and the delegate so nominated be present he shall be declared elected to membership on the Nominating Committee.

(*c*) Upon completion of the election of Divisional Representatives as provided for in clause (*b*) of this section any vacancies which remain shall be filled by nominations from the floor, and the candidates so nominated who receive the highest number of votes shall be declared elected. This election shall be decided on a single ballot and the Chairman of the General Council shall if necessary give the casting vote.

Section 2—Duties of Nominating Committee

The Nominating Committee shall meet on the day of its election and submit to a later session of the General Council:—

1. Nomination of the following officers of The Association: a President-Elect, a Chairman of the General Council and an Honorary-Treasurer.

2. Nomination of an Executive Committee which, in addition to those who are members *ex officio* (See Chapter VIII, Section 4), shall consist of thirteen members geographically distributed as follows: three shall be resident in each province in which an office of The Association is located and one shall be resident in each of the other provinces.

At its session, the Nominating Committee may receive in writing a Division's official nomination of a candidate or candidates for representation on the Executive Committee to which the Division is entitled. In the event of an official nomination being rejected by the Nominating Committee the reasons for such action shall be incorporated in its report to General Council.

3. *Rules of Procedure.*—The Committee shall be called to order by the President as Chairman of the Committee. In the absence of the President the General

PROPOSED CONSOLIDATED CONSTITUTION

*CHAPTER VI.—OFFICERS AND EXECUTIVE COMMITTEE

Section 1—Appointment of Nominating Committee

*(*a*) The General Council at its first session at the time of the annual meeting shall elect by ballot from among its members present a Nominating Committee of NINE not including the President who shall be *ex officio* a member of the Committee and Chairman thereof.

*(*b*) Each Division in The Association is entitled to appoint from amongst its delegates to General Council one member to the Nominating Committee. Provided this nomination be made in writing to the General Secretary prior to the annual meeting and the delegate so nominated be present he shall be declared elected to membership on the Nominating Committee.

*(*c*) Upon completion of the election of Divisional Representatives as provided for in clause (*b*) of this section any vacancies which remain shall be filled by nominations from the floor. The list so nominated shall contain the name of at least one member of each Branch Association represented at this session. The candidate of a Branch Association who obtains the highest vote amongst the candidates of that Branch Association shall be declared elected. The remaining members, if any, shall be declared elected by majority vote. This election shall be declared on a single ballot and the Chairman of General Council shall if necessary give the casting vote or votes.

**Section 2—Duties of Nominating Committee*

The Nominating Committee shall meet on the day of its election and submit to a later session of the General Council:—

1. Nomination of the following officers of The Association: a President-Elect, a Chairman of the General Council and an Honorary-Treasurer.

2. Nomination of an Executive Committee which, in addition to those who are members *ex officio* (See Chapter VIII, Section 4), shall consist of thirteen members drawn from General Council and geographically distributed as follows: three shall be resident in each province in which an office of The Association is located and one shall be resident in each of the other provinces.

At its session, the Nominating Committee may receive in writing a Division's official nomination of the candidate or candidates for representation on the Executive Committee to which the Division is entitled. In the event of an official nomination being rejected by the Nominating Committee the reasons for such action shall be incorporated in its report to General Council.

3. *Rules of Procedure.*—The Committee shall be called to order by the President as Chairman of the

CONSTITUTION FOR BRANCHES	CONSTITUTION FOR DIVISIONS	PROPOSED CONSOLIDATED CONSTITUTION
shall be presented to the General Council by the General Secretary.	Secretary shall convene the Committee and request the Committee to select, by open vote, the Chairman. The Committee shall then proceed to carry out its duties by open vote. In case of a tie vote the Chairman shall have the casting vote in addition to the vote to which he is entitled as a member of the Committee. When called for, the report of the Committee shall be presented to the General Council by the General Secretary.	Committee. In the absence of the President the General Secretary shall convene the Committee and request the Committee to select, by open vote, the Chairman. The Committee shall then proceed to carry out its duties by open vote. In case of a tie vote the Chairman shall have the casting vote in addition to the vote to which he is entitled as a member of the Committee. When called for, the report of the Committee shall be presented to the General Council by the General Secretary.
Section 3—Election of Officers and Executive Committee and Place of Meeting When the report of the Nominating Committee has been received by the General Council in session, other nominations may also be received from the floor. A ballot shall then be taken for each of the offices in turn and also for elective members of the Executive Committee by provinces in accordance with the By-Law for the guidance of the Nominating Committee, Chapter V, Section 2, paragraph 2. In case of a tie vote, the Chairman shall have the casting vote.	*Section 3—Election of Officers and Executive Committee* When the report of the Nominating Committee has been received by the General Council in session, other nominations may also be received from the floor. A ballot shall then be taken for each of the offices in turn and also for elective members of the Executive Committee by provinces.	**Section 3—Election of Officers and Executive Committee* When the report of the Nominating Committee has been received by the General Council in session, other nominations may also be received from the floor. A ballot shall then be taken for each of the offices in turn and also for elective membership of the Executive Committee by provinces.
CHAPTER VI.—DUTIES OF OFFICERS	CHAPTER VII.—DUTIES OF OFFICERS	CHAPTER VII.—DUTIES OF OFFICERS
Section 1—Duties of the President The President shall preside at the general sessions of The Association and shall perform such duties as custom and parliamentary usage require. He shall deliver a presidential address. He shall be a member *ex officio* of all committees of The Association. He shall be reimbursed for his legitimate travelling expenses while engaged in the business of The Association.	*Section 1—Duties of the President* The President shall preside at the general sessions of The Association and shall perform such duties as custom and parliamentary usage require. He shall deliver a presidential address. He shall be a member *ex officio* of all committees of The Association. He shall be reimbursed for his legitimate travelling expenses while engaged in the business of The Association.	*Section 1—Duties of the President* The President shall preside at the general sessions of The Association and shall perform such duties as custom and parliamentary usage require. He shall deliver a presidential address. He shall be a member *ex officio* of all committees of The Association. He shall be reimbursed for his legitimate travelling expenses while engaged in the business of The Association.
Section 2—Duties of the President-Elect The President-Elect shall be installed and shall assume the office of President at the first general session of the annual meeting next following his election to the office of President-Elect. He shall be a member *ex officio* of all committees of The Association. He shall be reimbursed for his legitimate travelling expenses while engaged in the business of The Association.	*Section 2—Duties of the President-Elect* The President-Elect shall be installed and shall assume the office of President at the General Annual Meeting next following his election to the office of President-Elect. He shall be a member *ex officio* of all committees of The Association. He shall be reimbursed for his legitimate travelling expenses while engaged in the business of The Association.	*Section 2—Duties of the President-Elect* The President-Elect shall be installed and shall assume the office of President at the first general session of the Annual Meeting next following his election to the office of President-Elect. He shall be a member *ex officio* of all committees of The Association excepting the Nominating Committee. He shall be reimbursed for his legitimate travelling expenses while engaged in the business of The Association.
Section 3—Duties of the Chairman of the General Council The Chairman of the General Council shall preside at all meetings of the General Council. He shall be a member *ex officio* of all Committees and Chairman of the Executive Committee. He shall be reimbursed for his legitimate travelling expenses while engaged in the business of The Association.	*Section 3—Duties of the Chairman of the General Council* The Chairman of the General Council shall preside at all meetings of the General Council. He shall be reimbursed for his legitimate travelling expenses while engaged in the business of The Association. He shall be a member *ex officio* of all Committees.	**Section 3—Duties of the Chairman of the General Council* The Chairman of the General Council shall preside at all meetings of the General Council. He shall be reimbursed for his legitimate travelling expenses while engaged in the business of The Association. He shall be a member *ex officio* of all Committees, excepting the Nominating Committee.

CONSTITUTION FOR BRANCHES

Section 4—Duties of the Honorary-Treasurer

The Honorary-Treasurer shall be the custodian of all moneys, securities and deeds, which are the property of The Association.

He shall pay by cheque only. Such cheques shall be countersigned by the Chairman of the General Council or other authorized officer of The Association and shall be covered by voucher.

He shall prepare an annual financial statement audited by a chartered accountant.

He shall furnish a suitable bond for the faithful discharge of his duties. The cost of the bond shall be borne by The Association.

He may receive for his services an honorarium to be determined by the General Council. He shall be reimbursed for his legitimate travelling expenses while engaged in the business of The Association.

He shall be a member *ex officio* of the Executive Committee.

Section 5—Duties of the General Secretary

The General Secretary shall be the Secretary also of the General Council and of the Executive Committee of The Association. He shall also be a member *ex officio* of all Committees of The Association. He shall give due notice of the time and place of all annual and special general meetings, by publishing the same in the official *Journal* of The Association, or, if necessary, by notice to each member. He shall keep the minutes of each meeting of the General Council and the Executive Committee in separate books and shall provide minute books for the secretaries of the different sections which he shall require to be properly attested by the secretaries thereof. He shall notify the officers and members of committees of their appointment and of their duties in connection therewith. He shall publish the official program of each annual meeting. He shall perform such other duties as may be required of him by the President, the General Council or the Executive Committee. All his legitimate travelling expenses shall be paid for him out of the funds of The Association and he shall receive for his services a salary to be determined by the Executive Committee.

CHAPTER VII.—THE GENERAL COUNCIL

Section 1—Meetings of the General Council

The General Council shall meet for at least the first two days of the annual meeting of The Association and thereafter, while The Association is in session, at the call of the Chairman. Before the close of the annual meeting it shall elect the officers and the Executive Committee and select the place for the next annual meeting, or, if advisable, for meetings up to three years in advance.

CONSTITUTION FOR DIVISIONS

Section 4—Duties of the Honorary-Treasurer

The Honorary-Treasurer shall be the custodian of all moneys, securities and deeds, which are the property of The Association.

He shall pay by cheque only. Such cheques shall be signed by two persons authorized to sign cheques of The Association and shall be covered by voucher.

He shall prepare an annual financial statement audited by a chartered accountant.

He shall furnish a suitable bond for the faithful discharge of his duties. The cost of the bond shall be borne by The Association.

He may receive for his services an honorarium to be determined by the General Council. He shall be reimbursed for his legitimate travelling expenses while engaged in the business of The Association.

He shall be a member *ex officio* of the Executive Committee.

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The General Secretary shall be the Secretary also of the General Council and of the Executive Committee of The Association. He shall also be a member *ex officio* of all Committees of The Association. He shall give due notice of the time and place of all annual and special general meetings, by publishing the same in the official *Journal* of The Association, or, if necessary, by notice to each member. He shall keep the minutes of the meetings of the General Council and of the Executive Committee in separate books and shall provide minute books for the secretaries of the different sections which he shall require to be properly attested by the secretaries thereof. He shall notify the officers and members of committees of their appointment and of their duties in connection therewith. He shall publish the official program of each annual meeting. He shall perform such other duties as may be required of him by the President, the General Council or the Executive Committee. All his legitimate travelling expenses shall be paid for him out of the funds of The Association and he shall receive for his services a salary to be determined by the Executive Committee.

CHAPTER VIII.—THE GENERAL COUNCIL

Section 1—Meetings of the General Council

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PROPOSED CONSOLIDATED CONSTITUTION

**Section 4—Duties of the Honorary-Treasurer*

The Honorary-Treasurer shall be the custodian of all moneys, securities and deeds, which are the property of The Association.

He shall pay by cheque only. Such cheques shall be signed by two persons authorized by the Executive Committee to sign cheques of The Association and shall be covered by voucher.

He shall prepare an annual financial statement audited by a chartered accountant.

He shall furnish a suitable bond for the faithful discharge of his duties. The cost of the bond shall be borne by The Association.

He may receive for his services an honorarium to be determined by the General Council. He shall be reimbursed for his legitimate travelling expenses while engaged in the business of The Association.

He shall be a member *ex officio* of the Executive Committee.

Section 5—Duties of the General Secretary

The General Secretary shall be the Secretary also of the General Council and of the Executive Committee of The Association. He shall also be a member *ex officio* of all Committees of The Association. He shall give due notice of the time and place of all annual and special general meetings, by publishing the same in the official *Journal* of The Association, or, if necessary, by notice to each member. He shall keep the minutes of the meetings of the General Council and of the Executive Committee in separate books and shall provide minute books for the secretaries of the different sections which he shall require to be properly attested by the secretaries thereof. He shall notify the officers and members of committees of their appointment and of their duties in connection therewith. He shall publish the official program of each annual meeting. He shall perform such other duties as may be required of him by the President, the General Council or the Executive Committee. All his legitimate travelling expenses shall be paid for him out of the funds of The Association and he shall receive for his services a salary to be determined by the Executive Committee.

CHAPTER VIII.—THE GENERAL COUNCIL

Section 1—Meetings of the General Council

The General Council shall meet for at least the first two days of the annual meeting of The Association and thereafter, while The Association is in session, at the call of the Chairman. Before the close of the annual meeting it shall elect the officers and the Executive Committee and select the place for the next annual meeting, or, if thought advisable, for meetings up to three years in advance.

CONSTITUTION FOR BRANCHES	CONSTITUTION FOR DIVISIONS	PROPOSED CONSOLIDATED CONSTITUTION
Section 2—Special Meetings of General Council During the interval between annual meetings the General Council shall meet at the call of the Executive Committee. For all such meetings of the General Council due notice shall be sent to each member, stating the purpose of the meeting. The Executive Committee, if it so decides, instead of calling such meetings of the General Council may refer important questions to the General Council and obtain its decision by means of a mail ballot. In the event of a mail ballot being taken, two-thirds majority vote shall govern.	*Section 2—Special Meetings of General Council* During the interval between annual meetings the General Council shall meet at the call of the Executive Committee. For all such meetings of the General Council due notice shall be sent to each member, stating the purpose of the meeting. The Executive Committee, if it so decide, instead of calling such meetings of the General Council may refer important questions to the General Council and obtain its decision by means of a mail ballot. In the event of a mail ballot being taken, two-thirds majority vote shall govern.	*Section 2—Special Meetings of General Council* During the interval between annual meetings the General Council shall meet at the call of the Executive Committee. For all such meetings of the General Council due notice shall be sent to each member, stating the purpose of the meeting. The Executive Committee, if it so decide, instead of calling such meetings of the General Council may refer important questions to the General Council and obtain its decision by means of a mail ballot. In the event of a mail ballot being taken, two-thirds majority vote shall govern.
Section 3—Duties of the General Council The General Council shall have supervision of all properties and of all financial affairs of The Association. It shall, through its officers, conduct all business and correspondence, and shall keep a record of all meetings and the receipt and expenditure of all funds, and shall report upon same in the *Journal* after the annual meeting.	*Section 3—Duties of the General Council* The General Council shall have supervision of all properties and of all financial affairs of The Association. It shall, through its officers, conduct all business and correspondence, and shall keep a record of all meetings and the receipt and expenditure of all funds, and shall report upon same in the *Journal* after the annual meeting.	*Section 3—Duties of the General Council* The General Council shall have supervision of all properties and of all financial affairs of The Association. It shall, through its officers, conduct all business and correspondence, and shall keep a record of all meetings and the receipt and expenditure of all funds, and shall report upon same in the *Journal* after the annual meeting.
Section 4—The Executive Committee may Act for the General Council In order that the business of The Association may be facilitated during the interval between annual meetings, the Executive Committee shall meet from time to time at the call of its Chairman and shall have all the rights and powers of the General Council. It shall conduct all necessary business. In case of a vacancy in any office on account of death or otherwise it shall have power to appoint successors. The President, the President-Elect, the Chairman of the General Council, the Honorary-Treasurer, the General Secretary, the Editor and the Managing Editor shall be members *ex officio* of the Executive Committee.	*Section 4—The Executive Committee may Act for the General Council* In order that the business of The Association may be facilitated during the interval between meetings of the General Council the Executive Committee shall meet from time to time at the call of its Chairman, and shall have all the rights and powers of the General Council. It shall conduct all necessary business. In case of a vacancy in any office on account of death or otherwise it shall have power to appoint successors. The President, the President-Elect, the Chairman of the General Council, the Honorary-Treasurer, the General Secretary, the Editor and the Managing Editor shall be members *ex officio* of the Executive Committee, but only the elective officers shall have the right to vote.	**Section 4—The Executive Committee may Act for the General Council* In order that the business of The Association may be facilitated during the interval between meetings of the General Council the Executive Committee shall meet from time to time at the call of its Chairman, and shall have all the rights and powers of the General Council. It shall conduct all necessary business. In case of a vacancy in any office on account of death or otherwise it shall have power to appoint a successor. In case of a vacancy occurring in the Executive Committee itself by death or otherwise, it shall have power to appoint a successor upon receiving an official nomination from the Branch Association or Division concerned. The President, the President-Elect, the Chairman of the General Council, the Honorary-Treasurer, the General Secretary, the Editor and the Managing Editor shall be members *ex officio* of the Executive Committee, but only the elective officers shall have the right to vote.
CHAPTER VIII.—COMMITTEES	CHAPTER IX.—COMMITTEES	CHAPTER IX.—COMMITTEES
Section 1—Duties and Powers of the Executive Committee The Executive Committee shall hold one or more sessions before the close of the annual meeting at which it is elected. At this meeting it shall appoint chairmen of the standing committees for the ensuing year. Between the meetings of the General Council, the Executive Committee shall represent the General Council in all its business affairs and shall exercise all the rights and powers of the General Council. The Executive Committee	*Section 1—Duties and Powers of the Executive Committee* The Executive Committee shall hold one or more sessions before the close of the annual meeting at which it is elected. At its first meeting it shall elect its Chairman and appoint the Chairmen of the Standing Committees for the ensuing year. Between the meetings of the General Council, the Executive Committee shall represent the General Council in all its business affairs and shall exercise all the rights and powers of the	**Section 1—Duties and Powers of the Executive Committee* The Executive Committee shall hold one or more sessions before the close of the annual meeting at which it is elected. At its first meeting it shall elect its Chairman and appoint the Chairmen of the Standing Committees for the ensuing year. Between the meetings of the General Council, the Executive Committee shall represent the General Council in all its business affairs

CONSTITUTION FOR BRANCHES

shall report to the General Council at the annual meeting and at such other times as the Chairman of the General Council may request.

The Executive Committee may meet when and where it may determine. On the request in writing of any three members of the Executive Committee, the Chairman shall call a special meeting. Five members, exclusive of the Chairman, shall constitute a quorum for the transaction of business.

The Executive Committee shall be responsible for the appointment of the General Secretary, the Editor, the Managing Editor, the Associate Secretaries, and any other appointive officers, and shall fix their salaries.

The Executive Committee shall have charge of the publication of the official *Journal* of The Association and of all published proceedings, transactions, memoirs, essays, papers and programs of The Association.

The Editor and Managing Editor shall present annual reports to the General Council and interim reports at each meeting of the Executive Committee. The Editor shall be reimbursed for his legitimate travelling expenses incurred on Association business.

The Executive Committee may appoint Editorial Boards to assist the Editors.

The Executive Committee shall appoint the auditor and shall have the accounts of the Honorary-Treasurer audited annually, or more often if desirable, and shall make an annual report on the same to the General Council.

Each member of the Executive Committee shall be reimbursed for his legitimate travelling expenses incurred in attending meetings of the Executive Committee other than the first meeting or meetings of the new Executive Committee, which may be held before the close of the annual meeting.

Section 2—Committee on Legislation

All matters relating to medical legislation, Federal or Provincial, and all matters requiring legislative action (made or contemplated) arising within The Association, or any of its branches, or any of its committees, shall be referred to the Committee on Legislation for information and for any necessary advice.

Section 3—Committee on Medical Education

To the Committee on Medical Education shall be referred all matters pertaining to medical colleges and medical education. It shall report upon the condition of medical education throughout Canada and upon any proposed change, and may suggest methods for the improvement of medical education.

CONSTITUTION FOR DIVISIONS

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PROPOSED CONSOLIDATED CONSTITUTION

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The Executive Committee may meet when and where it may determine. On the request in writing of any three members (with voting power) of the Executive Committee, the Chairman shall call a special meeting. Seven members (with voting power), exclusive of the Chairman, shall constitute a quorum for the transaction of business.

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CONSTITUTION FOR BRANCHES

Section 4—Post-Graduate Committee

To the Post-Graduate Committee shall be delegated by the Executive Committee, the responsibility of carrying out the post-graduate plans of The Association.

Section 5—Committee on Program

This Committee, with the assistance of the Chairman and Secretary of each scientific section, shall have complete charge of the preparation of the program for the annual meeting.

Section 6—Committee on Constitution and By-Laws

To the Committee on Constitution and By-Laws shall be referred all matters relating to the subject before action thereon is taken by the General Council.

Section 7—Committee on Archives

The Committee on Archives shall be responsible for collecting as far as possible (*a*) the obituaries of members dying since the last annual meeting; (*b*) all documents and information relating to the various members and activities of The Canadian Medical Association which are deemed worthy of preservation. The Editor of the *Journal* shall be a member *ex officio* of this Committee.

Section 8—Committee on Public Health

(*a*) It shall be the duty of this Committee to place itself in communication with the official and voluntary health organizations of the Dominion.

(*b*) It shall be the duty of this Committee subject to the approval of the General Council to keep the public informed through the various means available, on matters pertaining to health.

Section 9—Committee on Ethics and Credentials

To this Committee all matters of ethics and special questions of credentials shall be referred for consideration and report to the General Council or the Executive Committee.

Section 10—Committee on Economics

It shall be the duty of the Committee on Economics (excepting where otherwise provided) to advise the General Council upon (*a*) social legislation which includes medical services or benefits presumably for medical services; (*b*) remuneration and employment of physicians by lay bodies, hospital or official bodies, including Federal, Provincial and Municipal Governments.

CONSTITUTION FOR DIVISIONS

Section 4—Post-Graduate Committee

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Section 8—Committee on Public Health

It shall be the duty of this Committee to study and report upon all matters of Public Health which, in the opinion of the Committee, should engage the attention of The Association. To the Committee may be delegated such duties in relation to Public Health as in the opinion of General Council or Executive Committee should be undertaken by the Committee on behalf of The Association.

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It shall be the duty of the Committee on Economics, excepting where otherwise provided, to deal with (*a*) social legislation which includes medical services or benefits presumably for medical services; (*b*) remuneration and employment of physicians by lay bodies, hospital or official bodies, including Federal, Provincial and Municipal Governments; (*c*) to report thereon with such recommendations as it may see fit to the General Council.

PROPOSED CONSOLIDATED CONSTITUTION

Section 4—Post-Graduate Committee

To the Post-Graduate Committee shall be delegated the responsibility of carrying out the post-graduate plans of The Association.

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It shall be the duty of the Committee on Economics, excepting where otherwise provided, to deal with (*a*) social legislation which includes medical services or benefits presumably for medical services; (*b*) remuneration and employment of physicians by lay bodies, hospital or official bodies, including Federal, Provincial and Municipal Governments; (*c*) to report thereon with such recommendations as it may see fit to the General Council.

CONSTITUTION FOR BRANCHES	CONSTITUTION FOR DIVISIONS	PROPOSED CONSOLIDATED CONSTITUTION
Section 11—Committee on Pharmacy It shall be the duty of the Committee on Pharmacy to deal with (*a*) all matters arising out of the British Pharmacopœia or any Canadian Formulary or Pharmacopœia; (*b*) all matters arising out of the drug section of the Food and Drugs Act, the Narcotic Act, or the Patent and Proprietary Medicine Act, and (*c*) any inquiries from members of The Association relating to the use or standards of drugs.	*Section 11—Committee on Pharmacy* It shall be the duty of the Committee on Pharmacy to deal with (*a*) all matters arising out of the British Pharmacopœia or any Canadian Formulary or Pharmacopœia; (*b*) all matters arising out of the drug section of the Food and Drugs Act, the Narcotic Act, or the Patent and Proprietary Medicine Act, and (*c*) any inquiries from members of The Association relating to the use or standards of drugs.	*Section 11—Committee on Pharmacy* It shall be the duty of the Committee on Pharmacy to deal with (*a*) all matters arising out of the British Pharmacopœia or any Canadian Formulary or Pharmacopœia; (*b*) all matters arising out of the drug section of the Food and Drugs Act, the Narcotic Act, or the Patent and Proprietary Medicine Act, and (*c*) any inquiries from members of The Association relating to the use or standards of drugs.
Section 12—Committee on Hospital Service This Committee shall act in an advisory capacity to the Hospital Service Department of The Association.	*Section 12—Hospital Service Committee* This Committee shall act in an advisory capacity to the Hospital Service Department of The Association.	*Section 12—Hospital Service Committee* This Committee shall act in an advisory capacity to the Hospital Service Department of The Association.
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		**Section 14—Committee on Maternal Welfare* To this Committee shall be referred for consideration all matters concerning maternal welfare. It shall be the duty of the committee to devise and recommend to General Council ways and means for the reduction of maternal mortality and the improvement of maternal welfare.
		**Section 15—Committee on Nutrition* It shall be the duty of the Committee on Nutrition subject to the approval of the Executive Committee (*a*) to initiate studies upon the nutritional needs of the public of Canada; (*b*) upon request from public bodies, to act in an advisory capacity upon nutritional problems; and (*c*) to adopt measures, educational or otherwise, likely to improve the nutritional standards of the public of Canada.
Section 14—Special Committees Each Special Committee shall assume, by direction, such duties as are allotted to it, and shall make progress reports to the Executive Committee at each of the meetings of that body or at any other time that such reports may be required by the President, the Chairman of the General Council, or the Executive Committee.	*Section 14—Special Committees* Each Special Committee shall assume, by direction, such duties as are allotted to it, and shall make progress reports to the Executive Committee at each of the meetings of that body or at any other time that such reports may be required by the President, the Chairman of the General Council, or the Executive Committee.	*Section 16—Special Committees* Each Special Committee shall assume, by direction, such duties as are allotted to it, and shall make progress reports to the Executive Committee at each of the meetings of that body or at any other time that such reports may be required by the President, the Chairman of the General Council, or the Executive Committee.

CONSTITUTION FOR BRANCHES

Section 15—Reports of Committees

Reports of all Committees shall be printed and mailed to all members of the General Council at least one week before the annual meeting.

Section 16—Limitations of Committees re Finances

No Committee shall expend any moneys or incur any indebtedness or obligation on behalf of The Association without the sanction of the Executive Committee.

CHAPTER IX.—ADDRESSES AND PAPERS

Section 1—Addresses at Annual Meeting

All addresses delivered at an annual meeting shall immediately become the property of The Association, to be published or not, in whole or in part, as deemed advisable, in the *Journal* of The Association. Any other arrangements for their publication must have the consent of the author or of the reader of the same and of the Editor of the *Journal*.

Section 2—Publication of Papers Presented at Annual Meeting

All papers, essays, photographs, diagrams, etc., presented in any section shall become the property of The Association, to be published in the *Journal* of The Association or not, as determined by the Editor, and they shall not be otherwise published except with the consent of the author and of the Editor of the *Journal*.

Section 3—Disposition of Papers Presented at Annual Meeting

Each author of a paper read before any section shall, as soon as it has been read, hand it with any accompanying diagrams, photographs, etc., to the Secretary of the Section before which it has been presented. The Secretary shall endorse thereon the fact that it has been read in that Section, and shall then transmit it to the Editor of the *Journal*.

CHAPTER X.—PROVISIONS FOR DISCIPLINE

Section 1—If any Member of The Association, after due enquiry by the General Council or one of its Standing or Special Committees shall be judged by the General Council to have been guilty of disgraceful conduct in any professional respect, he (she) shall be liable to censure, or suspension, or expulsion from Membership in The Association by resolution of the Executive Committee, confirmed by a three-fourths vote at the next ensuing annual meeting of General Council.

CONSTITUTION FOR DIVISIONS

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Section 1—If any Member of The Association, after due inquiry by the Executive Committee shall be judged to have been guilty of disgraceful conduct in any professional respect, he shall be liable to censure, suspension or expulsion from membership in The Association by resolution of the Executive Committee, confirmed by a three-fourths vote at the next annual meeting of General Council.

PROPOSED CONSOLIDATED CONSTITUTION

Section 17—Reports of Committees

Reports of all Committees shall be printed and mailed to all members of the General Council at least one week before the annual meeting.

**Section 18—Limitations of Committees re Finances*

No Committee shall expend any moneys or incur any indebtedness or obligation on behalf of The Association without the sanction of the General Council or the Executive Committee.

CHAPTER X.—ADDRESSES AND PAPERS

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CONSTITUTION FOR BRANCHES

Section 2—Should any Member of The Association be convicted of any criminal offence, or have his (her) name removed from the register of the Medical Council of Canada, or of the licensing body of any Province of Canada, because of felonious or criminal act, or disgraceful conduct in any professional respect, the Executive Committee may, by resolution, confirmed at the next ensuing annual meeting of the General Council, by a three-fourths vote of those present, censure, or suspend, or expel such member from Membership in The Association.

Section 3—Any Member suspended or expelled by resolution, as aforesaid, shall thereby forfeit all his (her) rights and privileges as a Member of this Association.

Section 4—Any Member suspended or expelled by resolution as aforesaid shall, subject to conditions imposed by the Executive Committee, be restored to membership upon resolution of the Executive Committee, confirmed at the next ensuing annual meeting of General Council.

Section 5—By subscribing to the application for membership under the terms of the By-Laws and Code of Ethics and becoming a Member of The Association, every Member attorns to these By-Laws and agrees to such right of discipline as aforesaid and thereby specifically waives any right or claim to damages in the event of his (her) being so disciplined.

CHAPTER XI.—AMENDMENTS

1. Notice of Motion, by individual Members or others, to amend the By-Laws, must be placed in the hands of the General Secretary three months before the date of the annual meeting.

2. Amendments may be proposed by the General Council, the Executive Committee or the Committee on Constitution and By-Laws without notice of motion, but the proposed amendments shall be published in the *Journal* in two issues preceding the annual meeting.

3. The By-Laws shall be amended by a two-thirds vote of the members of the General Council in session present and voting.

CONSTITUTION FOR DIVISIONS

Section 2—Should any Member of The Association be convicted of any criminal offence, or have his name removed from the register of the Medical Council of Canada, or of the licensing body of any Province of Canada, because of felonious or criminal act, or disgraceful conduct in any professional respect, the Executive Committee may, by resolution, confirmed at the next ensuing annual meeting of the General Council, by a three-fourths vote of those present, censure, or suspend, or expel such persons from Membership in The Association.

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Section 5—By subscribing to the application for membership under the terms of the By-Laws and Code of Ethics (see appendix) and becoming a Member of The Association, every Member attorns to these By-Laws, and agrees to such right of discipline as aforesaid, and thereby specifically waives any right or claim to damages in the event of his being so disciplined.

CHAPTER XII.—AMENDMENTS

1. Notice of Motion by one or more Members, to amend the By-Laws, must be placed in the hands of the General Secretary three months before the date of the annual meeting.

2. Amendments may be proposed by the General Council, the Executive Committee or the Committee on Constitution and By-Laws without notice of motion, but the proposed amendments shall be published in the *Journal* in two issues preceding the annual meeting.

3. The By-Laws shall be amended by a two-thirds vote of the members of the General Council in session present and voting.

NOTE: Throughout these By-Laws, masculine designations are to be interpreted as including feminine.

PROPOSED CONSOLIDATED CONSTITUTION

**Section 2*—Should any Member of The Association be convicted of any criminal offence, or have his name removed from the register of the Medical Council of Canada, or of the licensing body of any Province of Canada, because of felonious or criminal act, or disgraceful conduct in any professional respect, the Executive Committee may, by resolution, confirmed at the next ensuing annual meeting of the General Council, by a three-fourths vote of those present, censure, or suspend, or expel such persons from Membership in The Association.

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Section 3—The By-Laws shall be amended by a two-thirds vote of the members of the General Council in session present and voting.

*CHAPTER XIII.—THE OFFICE

Until changed by General Council the offices of The Association shall be at Toronto and Montreal.

NOTE: Throughout these By-Laws, masculine designations are to be interpreted as including feminine.

GENERAL COUNCIL, CANADIAN MEDICAL ASSOCIATION—183
AS AT PRESENT CONSTITUTED

Officers of the Association

Patron
Chairman, G.C.
President
President-Elect
Past-Presidents—19
Honorary Treasurer
*General Secretary
*Associate Secretary
*Editor

Department of Pensions and National Health
2 Delegates

26

Chairmen and Secretaries of Sections

Medicine
Surgery
Ophthalmology
Dermatology
Anæsthesia
Radiology
Rheumatic Diseases
Urology
Otolaryngology
Obstetrics and Gynæcology
Pædiatrics
History of Medicine
Military Medicine

13 x 2 = 26

Presidents and Secretaries of Divisions and Branch Associations plus Delegates Proportionate to Membership—Article IX.

Ontario	Quebec	Nova Scotia
2 + 11	2 + 7	2 + 7
Prince Edward Island	**Saskatchewan**	**Alberta**
2 + 5	2 + 7	2 + 7
British Columbia	**Manitoba**	**New Brunswick**
3 + 7	2 + 7	2 + 7

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Chairmen and Secretaries of Committees

Standing

Executive
Legislation
Medical Education
Post-Graduation
Central Program
Archives
Public Health
Ethics and Credentials
Economics
Pharmacy
Hospital Service
Cancer
Constitution and By-Laws

Special

Awards and Scholarships
Ceremonial
Finance
Hospital Interns
Laboratory Technicians
Maternal Welfare
Meyers Memorial
Nutrition
Osler Memorial

22 x 2 = 44

* No voting power

NOMINATING COMMITTEE

President + 9 members.
Divisions each nominate one member.
Remainder are elected from floor of General Council under provisions designed to ensure representation of Branch Associations.

EXECUTIVE COMMITTEE

President
President-Elect
Chairman General Council
Honorary Treasurer
*General Secretary
*Editor
*Managing Editor
and 13 members

3 members each from Ontario and Quebec, one each from the remaining provinces. Divisions name their representatives for the Nominating Committee. Remainder are appointed by Nominating Committee.

* Appointive officers. No voting power.

All of which is respectfully submitted.

R. I. HARRIS,
Chairman.

Approved.

It was agreed that General Council suspend Section 2, Chapter XII of the By-Laws which requires publication in the *Journal* of amendments, in order that the Consolidated Constitution and By-Laws might be adopted at this meeting.

MANITOBA MEDICAL ASSOCIATION AND FEDERATION

Dr. F. D. McKenty, one of the delegates on General Council from the Province of Manitoba, explained clearly the situation in the Province of Manitoba with regard to Federation with the C.M.A., indicating that there is a possibility that Manitoba Medical Association may agree to make application to become a Division at the time of their annual meeting in September. The following resolution was passed:

> That, in the event of the Manitoba Medical Association deciding to become a Division of the C.M.A. at its annual meeting in September, 1939, the Executive Committee be given power to accept the application of the Manitoba Medical Association, thus making provision for Manitoba to become a Division forthwith.

REPORT OF THE COMMITTEE ON ECONOMICS

Mr. Chairman and Members of General Council:—

No outstanding event in the field of Medical Economics in Canada has occurred since Council last met in Halifax a year ago.

The Royal Commission appointed to study Dominion-Provincial relations has not yet submitted its findings to the Federal Government. It is understood that, following this submission, the report will be referred for full discussion to a joint meeting of representatives of the Provincial and Federal Governments. Possible action by the Federal Government on any of the recommendations contained in the report is, therefore, still somewhat in the future.

During the last year the Committee on Medical Economics has undertaken the following work at the request of the Executive Committee:

(1) The collection of all information available concerning Medical Service Schemes in operation or contemplated in any part of Canada.
(2) A study of Contract Practice.

All the provinces are co-operating in this work and it is hoped at a later date when complete returns are in, to submit full reports.

In addition, the Committee on Medical Economics has invited the various divisions and branches to undertake in their provinces the following:

(1) An examination of the present status of Lodge Practice.
(2) A study of Voluntary Health Insurance and Voluntary Hospital Insurance.

So far, gratifying responses have been received from many of the provinces where a great deal of work has already been accomplished and it is expected that valuable information from the provinces on these subjects will be made available to the Committee on Medical Economics.

From a study of this information it is hoped that it may be possible to make certain definite recommendations to the Association.

REPORTS FROM BRITISH COLUMBIA AND MANITOBA

All provinces were asked to report anything of interest that had occurred in the field of Medical Economics in the last year. From many of the provinces came back replies that nothing new had developed during the interval since last meeting of Council.

In Ontario the reports on the last year's work of the Associated Medical Services Incorporated and Medical Relief have not yet been published. In Saskatchewan nothing new of note has been developed in connection with its relief work or the Municipal Doctor System.

The following notes have been received from Manitoba and British Columbia.

BRITISH COLUMBIA

A Study of Economics is deservedly prominent in the provincial program. Economic conditions have impressed the need of concentration on the problems of the profession. Security in practice must be assured. Unity of thought and action is essential.

The Committee on Economics of the Council of the College of Physicians and Surgeons of British Columbia has been strengthened and now includes in its personnel representatives from each medical district in the province.

During the 1937 Annual Meeting of the British Columbia profession, and again in 1938, conferences on Medical Economics provided an opportunity to discuss freely many phases of practice,—much information was gathered and the various viewpoints and opinions presented led to a broader understanding of the other man's problems. The 1939 Annual Meeting will be extended to four days and thus provide that a longer period may be devoted to these vital questions.

At this time sub-committees are engaged in studies of Medical Contracts, all Contributory Schemes, Lodge practice and the present status of those members who serve in salaried positions. Certain additions and alterations in the Schedule of Minimum Fees are under consideration by a Special Committee. There is a real need to secure better terms for those members who are engaged in what is known as Contract Practice.

It is very heartening to know that the Committee on Economics of the Canadian Medical Association is attempting to obtain information regarding medical contracts from all provinces. It is hoped that accepted principles will be laid down, standards will be set up, uniformity attained and unity obtained. This form of practice in the province of British Columbia presents similar perplexities to those encountered elsewhere. The recognition of an evil suggests the application of a remedy. Standardization of terms of Medical Contracts will do much to restore confidence in the doctor to whom fear is a deterrent in attempting to improve his position.

Certain problems which present in British Columbia are Dominion-wide in existence and origin and may be more successfully approached nationally. These may arise in the services of several branches of Federal departments or possess a national complexion through association as in some lodges or insurance companies. Regulations by and remuneration allowed in Federal departments affect those members who serve under the Department of Pensions and National Health,—covering service to mariners, veterans, etc., and in the Indian Affairs Branch of the Department of Mines and Resources.

Voluntary hospital schemes operating in several centres in the interior of British Columbia are reported to be working satisfactorily. Under these plans the head of the family or a single person may purchase a ticket for $1.00 per month (in some hospitals $1.25 is required) and this provides for hospital bed and certain ancillary services (X-ray and Laboratory) for the subscriber and family, with an age limit on dependents. Where interest is enlisted and a large membership enrolled, the hospitals find that these voluntary schemes are very helpful to all parties.

Contributory Schemes, under which the fund for medical services is provided by deductions from payroll, are operating in some larger industrial organizations. These permit of participation by all doctors, allowing free choice of doctor by the member or dependent. One scheme pays 75 per cent of the doctor's account which is based on the Schedule of Minimum Fees. Another scheme which permits of free choice of doctor protects the employee-contributor and his dependents against the larger crippling expenses incurred in the more serious illnesses. It is the responsibility

of the member to provide for payment of medical benefits up to $25.00. The 25 per cent discount on doctors' bills is deductible only from those accounts which exceed the $25.00 limit. This scheme provides a very generous and comprehensive service and promises to survive in solvency. These voluntary schemes operated among employees and under control of their own elected authority are supported loyally and their success is at least partially assured by the interest and pride of the members in their own organization.

In the study of Medical Contracts and the completion of the Questionnaire recently distributed to certain members throughout the province, who are engaged in contract practice, much valued opinion based on experience is being compiled. These questions and answers bear on:

The need or otherwise for existence of contracts served by one or more doctors in larger centres where sufficient doctors are available to permit of free choice of doctor.

The value of contributory schemes—to patients—to doctors—to service.

The need for medical contracts where the doctor in isolated areas must be assured a sufficient income.

The method of payment and the amount of the employees' contributions by deductions from pay-roll, —employees with or without resident dependents.

The exclusion of hospitalization.

The exclusion of supplying medicine, etc., where drug store exists.

The exclusion of Workmen's Compensation Board cases from contracts.

Contracting for the inclusion of medical service by hospitals, associations, church and other organizations.

The employment of doctors to provide these services through hospital contracts.

The supplying of other services by doctors under salary,—radiologists', anæsthetists' and other services.

The employment of doctors on salary by lay organizations which contract to supply medical, surgical, obstetrical and other services.

The extent and nature of services to be supplied under medical contracts.

The inclusion of surgery—for employee—for dependents.

The inclusion of all ordinary services.

The inclusion or exclusion of obstetric and allied service.

The inclusion of services of the specialist to be paid by doctor.

The advisability of supplying other than ordinary medical and surgical care with the addition of obstetrics where dependents are included.

Should the scheme be comprehensive and include all ordinary service which might be expected normally from a general practitioner where a sufficient fund, which would allow of ample remuneration, is maintained?

What limitations would be considered necessary where medicine must be provided by doctor?

Should sera, vaccines, biologicals, and appliances be supplied? Provision of transportation—for patient —for doctor? Assistance at operations, etc.? Payment of extra services—anæsthetists'—x-ray and laboratory services?

There is much to be done. We are told that the old order is passing. We must accept our responsibility in leadership as those best fitted to plan our own destiny.

M. W. THOMAS,
Executive Secretary.

MANITOBA

I cannot say that there is anything outstanding to report. There is increased interest on the part of the public in health insurance, and as a result several members of our profession who had previously shown no interest, are now having to learn a good deal. They get invited by an organization, service club, fraternity society, etc., to give an address on the subject. I have been driven to keep sets of useful notes and outstanding points for the lecturer who comes with a request for information. I have had three sets on loan in one week. Then, our Manitoba Hospital Service Association has gone over very well. Though only starting in January ten thousand employees and dependents had joined up for protection by April 1st. The question is being asked why cannot they pay our doctors' bills the same way.

There has been expressed a desire by the Relief Committee of the Winnipeg City Council to alter our medical relief scheme. The only plan so far submitted to us had not been carefully considered. Discrepancies in certain claims and promises were pointed out, and we refused to consider it. In addition to the temporary unemployed, we were asked to take over all the permanent wards of the state, social welfare cases, old age pensions, widows and orphans under the Act, etc. All treatment in hospital was to be free. City Councils appear to have the idea that the services are paid for in full; we point out that the doctors agreed five years ago to take half the load, and that if a permanent scheme is to be set up it will have to be on a different financial basis. We have the material but have not yet started our statistical survey for 1938. There was a lowered incidence of illness over many parts of the continent last year; it was apparent here. Figures based on such a survey might be very misleading.

Our rural survey covering the ailments of fifteen thousand people will have completed its first year in May, and within a reasonable time statistics should be available.

The maternal mortality survey will be presented by the special committee. Information to date is that there should be 8,000 returns out of a possible 10,000 attended by physicians. Returns are fairly complete as far as covering the services rendered.

We have undertaken a survey of the problems of the rural practitioner as regards the treatment of indigents, including those on relief. All the material is not yet available, and the country practitioner does not appear to be fond of answering letters. It is interesting to note the wide variance in the consideration for their medical officers by different councils.

I am getting together some figures for Dr. Barrett on the extra services supplied in hospitals to public ward patients for which no direct payment is made. These would include use of operating room, anæsthetic, x-ray, B.M.R., etc.

As you see, nothing outstanding has happened, but these notes may show the trend.

E. S. MOORHEAD,
Chairman, Committee on Sociology.

COMPULSORY HEALTH INSURANCE

At the meeting of the Executive Committee held in Ottawa in October, 1938, the following resolution was passed:

"That the Committee on Medical Economics undertake to secure from the several provinces a statement as to the position which each provincial medical association now takes in regard to the Canadian Medical Association defining a policy for or against health insurance.

That the committee endeavour to include in its report to this executive committee, in minutest detail, such information as will help the committee to define the position which the Canadian Medical Association should take or such advice as should be passed to General Council for consideration at its next meeting.

That a copy of the questionnaire and covering letter which the Committee on Economics may send to its provincial representatives be also sent to the secretary of each provincial division or branch.

That the chairman of the Committee on Economics be invited to attend the next meeting of the Executive

Committee to present the report herein requested.''

The Committee on Economics undertook this work and submitted a special confidential report to the Executive Committee at its March meeting.

At the request of the Executive Committee, the Committee on Economics herewith submits for the information of General Council an abridged form of this special report, containing all the essential details.

In order to obtain the necessary information concerning the attitude of the medical profession to the question of Compulsory Health Insurance the following questionnaire, in attempted harmony with the resolution passed by the Executive, was sent out with a covering letter to all members of the Executive, to the Secretaries of all provincial divisions and branches and to all corresponding members of the Committee on Economics:

QUESTIONNAIRE *Re* COMPULSORY HEALTH INSURANCE

I. Does the Medical Association agree that the time has arrived when the Canadian Medical Association should define a policy either for or against a Compulsory Health Insurance that is based on the principles adopted by General Council at the Annual Meeting of the Canadian Medical Association at Ottawa in 1937, and printed in the *Journal* of the C.M.A., in September of that year?

If so please give full reasons for this decision.

II. If the Medical Association does not agree that the time has yet come, will you please give me in as full detail as possible the various reasons put forward in defence of the argument that the Canadian Medical Association should take no action at the present time?

III. If the Medical Association agrees that the time has come for the Canadian Medical Association to take a stand, is it in favour of:—

1. A stand for Compulsory Health Insurance?
2. A stand against Compulsory Health Insurance?

IV. If your Provincial Association is in favour of a stand for Compulsory Health Insurance, please give me in as full detail as posisble the various reasons and arguments put forward in support of this stand being taken.

V. If your Provincial Association is in favour of a stand against Compulsory Health Insurance, again, please give me in full detail the various reasons and arguments advanced in support of this stand being taken.

The covering letter was as follows:—

Dear Doctor:—

At the meeting of the Executive of the Canadian Medical Association held in Ottawa, October 27th, and 28th, the Committee on Economics was instructed as follows:—

1. ''That the Committee on Economics undertake to secure from the several provinces a statement as to the position which each Provincial Medical Association now takes in regard to the Canadian Medical Association defining a policy for or against Health Insurance.''
2. ''That the Committee on Economics endeavour to include in its report to this Executive Committee, in minutest detail, such information as will help the Committee to define the position which the Canadian Medical Association should take, or such advice as should be passed to General Council for consideration at its next meeting.''

Enclosed please find a questionnaire, the answers to which, I hope, will define definitely the policy of the various provinces.

May I ask for your full co-operation in obtaining for me the answers as they apply to your Province?

It is most urgent that this should be done as soon as possible in order that our Committee on Economics may be able to submit a full report, as requested, to the Executive at its next meeting, early in the Spring.

I have sent copies of the questionnaire and this letter to Dr. the member of the Executive for your province and also to Dr. Secretary of your Provincial Association, and have asked them to co-operate with you in this matter.

The answers, as you can see from the instructions of the Executive, should be amplified with as full details as possible regarding the reasons and arguments advanced in support of them.

The Executive and your Committee are most anxious that the answers should be authoritative and represent the policy of the united profession in your province so may I ask that you consult, as soon as possible, with the Executive of your Provincial Association and its Provincial Committee on Economics.

The report of the Committee on Economics to the Executive is to be confidential so please be frank in giving the various reasons advanced for the answers given.

If there is any more information that I can give you please call on me at once. In the meantime, may I count on your proceeding with this matter with as much speed as possible?

Yours sincerely,

WALLACE WILSON,
Chairman, Committee on Economics, C.M.A.

In an attempt to avoid confusion in the minds of those studying the questionnaire it was made as simple and straightforward as possible. The result may have invited just that confusion that more detailed questions might have avoided. It is sometimes easy to forget that those answering a questionnaire may approach it from different angles of thought than the framers.

No replies were received from two of the Provinces. Two of the provinces replied that the subject had not yet been placed before their provincial associations for discussion and that no answers could be given until this was done. One province stated that the medical profession in that province was not sufficiently informed on the subject of Health Insurance for the Executive to recommend that the Canadian Medical Association should define a policy at the present time. The remaining provinces all answered the questionnaire fully and in detail and three members of the profession sent personal letters outlining their views.

A synopsis of the answers received is as follows:—

I. The official representatives in one province recommended that the Canadian Medical Association do nothing at the present time concerning the drafting of a plan or the public declaration of a policy, but that the Association proceed to:—

(1) educate the profession in the many phases of Medical Economics,
(2) attempt, as soon as possible, a study, undertaken by experts, of Compulsory Health Insurance and allied subjects.
(3) collect information on various phases of Medical Economics.

Points arising in the discussion were:

1. In 1934, the Canadian Medical Association had definitely refused to take a stand for or against Health Insurance; had gone on record in favour of a National Survey, and, before the Rowell Commission in 1938, it had practically re-affirmed this position. Had anything occurred in the interval that should justify a change in policy? Would it not be wiser to await the publishing of the Royal Commission's report and the discussions of the inter-provincial conference that is to follow before attempting to come out with a policy?

2. So far Health Insurance has been the only possible solution dealt with. We cannot be sure that if a complete and adequate survey were made, Health Insurance would be suggested as the right solution. It might be found that—

(*a*) Adequate facilities, *e.g.* hospitals, laboratories, etc., are at present so deficient that an efficient scheme of Health Insurance would be impossible.

(*b*) That funds are not available or attainable to implement an adequate scheme.
(*c*) That other plans or schemes might be better, or, at least better as a beginning, *e.g.*, increase of hospitalization, laboratory and diagnostic facilities, Voluntary Health Insurance.

3. The great weakness of plans so far suggested is that preventive medicine has been practically ignored in favour of the therapeutic measures of Health Insurance.

4. The Canadian Medical Association could define a policy based on broad general principles. There was a danger in being passive in that outside influences might step in and assume control.

5. Defining a policy would be followed very closely by "drafting a plan" and that was one thing the Canadian Medical Association must not try to do now because it needs much more information before it is qualified for the task.

Health Insurance is not a medical problem but an economic one. Costs are the stumbling block.

6. Action by the Canadian Medical Association should be encouraged. It should endeavour to secure a Royal Commission and get it started investigating the problem of medical care of the people.

7. A Dominion survey is a myth. Provincial bodies will not give up their rights to the Federal Government. This province will probably have to work out its own salvation. The Canadian Medical Association should make up its mind regarding principles that should govern Health Insurance and be ready to throw its weight on the side of these in each province.

SUMMARY OF REASONS GIVEN FOR NOT AGREEING TO DEFINING A POLICY

1. The Canadian Medical Association has not sufficient data or information, nor adequate access to economic facts, costs, etc., to enable it to define a policy for or against Health Insurance. These can only be obtained through economic and statistical surveys.

2. That the suggestion of a Dominion survey is of supreme importance as any measures taken to improve the health of the people should be national in scope.

3. In 1934, 1937 and 1938 the "principles" as set out by the Committee on Economics were affirmed and the position of the Canadian Medical Association before the Rowell Commission was that, not knowing all the facts, the Canadian Medical Association could not define a policy nor take a definite stand. Nothing to date has happened that should induce the Canadian Medical Association to change this position.

4. There has not been sufficient consideration of other possible solutions of the problem, *e.g.*, preventive medicine, diagnostic facilities, hospital plans, Voluntary Health Insurance or a gradual introduction of any or all of these in preparation for a larger scheme. So far Compulsory Health Insurance has been the only plan considered and it has not been shown that of necessity it will prove adequate or advisable.

II. Another province recommended certain modifications of the principles of Compulsory Health Insurance as agreed to at the Ottawa meeting, and in addition recommended the following:—

(*a*) The right of the public, which requires a complete service, to request the doctors to suggest a plan by which it can pay its bills.
(*b*) That a complete service including medical care, general and specialist, hospitalization, ancillary treatments, nursing and dental services, and health supervision should be provided.
(*c*) Amended as follows:—
The necessity that there should be state supervision as, for example, in the Banking Act and the Insurance Act, but not state control.
(*d*) That it should be compulsory, otherwise only the unhealthy or very careful will take part.
(*e*) That it should include all indigents. These people receive education, hospitalization, food, clothing, shelter, etc., though making no contribution.
(*f*) That there should be free choice of doctor; otherwise it becomes a state service.
(*g*) That no layman must come between the doctor and his patient insofar as diagnosis and treatment are concerned.
(*h*) That the doctors should have minority representation in general administration, and majority representation in purely medical affairs.
(*i*) That in many sparsely populated areas doctors would have to be paid by an inclusive salary.
(*j*) That payments should be on a capitation basis for the family doctor, and on a "fees for services" basis for the specialist.
(*k*) That the respective spheres of practice of general practitioner and specialist must be defined.
(*l*) That the patient should not have the right to demand special services or treatment.
(*m*) That there should be an income limit for the insured.
(*n*) That there must be assurance of sufficient material for teaching purposes.
(*o*) That there should be a limit on the number of potential patients.
(*p*) That a doctor's pension scheme should be compulsory.
(*q*) That a disciplinary board should be constituted by the College of Physicians and Surgeons.
(*r*) Deleted on the grounds that it was incompatible with clause one of the recommendations of the Committee on Economics of the Canadian Medical Association.
Deleted—That the service should be controlled by the Department of Health through a Commission with medical representation.
(*s*) That increased co-operation by the general practitioner in preventive work must be stressed.

It then agreed on the definition of a policy now and pointed out that the Canadian Medical Association should be ready to submit a plan if called on by a Government. It was finally pointed out that the report and recommendations came from the official representatives, but were not actually an expression of opinion from the profession in the Province as a whole.

III. A third province agreed that the time had come for the Canadian Medical Association to define a policy for the following reasons.

(1) The realization of a need for a more adequate distribution of medical services has aroused public interest in health insurance as a means of obtaining this. The people of Canada naturally look to the organization representing medical opinion in this country for a definite expression of opinion on this important question.
(2) In two provinces legislation has been formulated to introduce health insurance and it is likely that other legislatures will also pass upon this question. This makes it essential that we shall have defined our attitude.
(3) Assuming that compulsory health insurance may possibly be introduced, it would seem wise to anticipate the event by defining a policy and using every effort to direct the trend towards that form of Health Insurance which we believe to be best for public and profession.
(4) In its effort to uphold the principle of a national form of health insurance for Canada, the Canadian Medical Association has advocated a survey of the medical needs of the Dominion by a Royal Commission, and has heretofore not declared for or against health insurance. As it seems to us doubtful that such a Commission

will be appointed, the march of events already noted makes it all the more necessary to arrive at a settled policy.

(5) The attitude of the American Medical Association, as interpreted to the newspaper-reading public, has been represented as opposed to any change in the present system of medical care. We believe that the medical profession of Canada takes a much more favourable attitude towards contributory and compulsory health insurance and it is important that our views be defined in order that our position may be plainly stated when the time is opportune.

(6) We believe that, as a body representative of the will of the medical profession of this country, the Canadian Medical Association has a duty to its members in expressing their views on this important question.

It further agreed that the declaration be for Compulsory Health Insurance and the following points were brought out in the discussion.

There is a very evident need for the provision of a more adequate medical service for the low income groups of the population, and this need is more acute in relation to domiciliary care than it is for hospitalized patients. The removal of the economic barrier between doctor and patient should encourage earlier consultation and so permit many diseases to be detected in the incipient stages with consequent benefit to the patient. The provision of adequate home care should reduce the number of patients referred to hospitals. The fear was expressed that complete State control of a plan of compulsory health insurance might give the government too great political power. Under any scheme of health insurance, provision should be made for the needs of teaching hospitals for clinical material for the training of students. Voluntary plans of health insurance should be encouraged for those persons immediately above the income level of those compulsorily insured. The representation of organized medicine in the administration of any compulsory health insurance plan should be assured and definitely provided for.

We believe that, granting the need for a more adequate distribution of medical services among the low income group, this need can best be satisfied by contributory health insurance on a compulsory basis. Experience elsewhere has demonstrated that legislative action, ensuring the application of the plan to all members of the group under consideration, is necessary to completely provide the service to those who need it most.

We believe that the application of compulsory health insurance would increase the income of the medical profession by providing remuneration to the doctors for the care of those persons who now are unable to pay for medical care.

IV. The fourth province answering the questionnaire recommended that the Canadian Medical Association define a policy but there was, as a result of a canvass of the profession, a wide diversity of opinion as to what that policy should be. The vast majority of the active practitioners were dissatisfied with the conditions of practice as at present existing, but it was evident further information and education were necessary before the profession would show any unanimity as to what they wanted.

V. Two of the letters received from members of the profession are as follows:

My dear Doctor,

The invitation contained in your covering letter of January 20th, which accompanied the minutes of the meeting of the Committee on Economics prompts me to attempt the task of setting on paper my opinions regarding health insurance.

The scheme outlined in the September, 1937, issue of the *Journal* has many defects. These were discussed at some length at our meeting. One of the most important is that concerned with hospitalization of the beneficiaries under the proposed scheme. As I interpret the clause relative to this, it would completely change the status of all those patients who now occupy public wards. They would become the wards of the insurance scheme; their hospitalization costs paid for by the funds set up and the doctors reimbursed for their treatment. The effect of this would end public ward patients as they exist to-day. Such a change would be disastrous to teaching hospitals. Moreover, it would set back progress in medicine for a long period of time. If the treatment of the group of individuals who are now public ward patients is to be paid for, it is certain they will never be admitted to teaching hospitals with a closed staff. On the contrary, the tendency will be for the practitioner to admit to open hospitals where he can continue to look after them and to operate upon them for the sake of the fee he will obtain. Our efforts to raise the standard of the practice of surgery by adequate training of competent young men will be frustrated. Large numbers of practitioners will operate upon their own patients.

A fundamental difficulty in every discussion on this subject is our complete lack of accurate information regarding the need for subsidized medical service for (name of Province). Does such a need exist and if so, how great is it? It has been my experience that meetings called to discuss the subject commence with the assumption that a large proportion of the population are in dire need of a *complete* medical service subsidized by the State. Starting with such a premise it is natural that the schemes evolved are Utopian in their scope. In my judgment there is reason to believe that the need for subsidized medical services is not as great as has often been assumed. In any case it is certainly true that we lack accurate information on this fundamentally important basis of any discussion. I suggest that one of the most important things we can do is to persuade the (name of Province) Medical Association or the Canadian Medical Association to conduct a survey for the purpose of establishing the need which actually exists. The Canadian Medical Association has advocated a Royal Commission. There seems little likelihood of attaining this and failing such a fact-finding organization the Canadian Medical Association might well undertake it themselves. When one considers that our present problem is in large part due to the depression and that an era of prosperity would completely change the picture; when one considers the extreme variations which exist in the cost of living in different communities, I do not see how we can hope to plan wisely and soundly without more accurate knowledge of the existing facts. If they cannot be obtained otherwise, they should be obtained by ourselves.

Lacking actual knowledge of the existing needs we are forced to rely upon personal impressions. It is this which has made discussion in Committee so difficult and confused. Each member's point of view is different and is determined by the nature of his practice. In recent months I have taken some pains to obtain information from as many sources as possible and from this information I have formed the following impressions of the economic status of (name of Province) citizens and their need for subsidized medical services.

Citizens of (name of Province) may be divided into economic groups as indicated below and with each group is indicated their apparent need for improved medical service.

(*a*) *Unemployed without means.* Individuals in this group require medical service in the home completely paid for by the state just as is every other necessity, (food, shelter, fuel, clothing). If hospitalization is necessary this is adequately provided for in public wards under the existing Hospital Act and no change is necessary.

(*b*) *Employed at low income or living without employment on a small income, (e.g. pension).* Income barely sufficient for subsistence. This group requires medical care in the home partially or completely cared for by the state,

preferably the former. Medical care in hospital in public ward is adequately provided for under the present Hospital Act and no need for change exists.

(*c*) *Modest Income Group (artisans, clerks, teachers, etc.)* Generally speaking these people can pay for medical care in home and in hospital unless they are unexpectedly visited by a prolonged and costly illness. This group needs education in the advantages of voluntary health insurance. It might well be that government encouragement and perhaps support should be given these schemes, both for complete medical care and for group hospitalization.

(*d*) *Upper Middle Class (University Staff, bank managers, minor executives, income say $2,500 to $4,000).* This group also would best be cared for by voluntary health insurance schemes. They should be educated and encouraged to join them. The government might consider the advantages of bonusing membership in voluntary health insurance schemes, *e.g.*, by deduction of cost of health insurance from income tax.

(*e*) *Upper Income Brackets.* No problem in medical service exists here.

It is my impression that such need for improved medical service as does exist in (name of Province) is largely, if not entirely, for medical service in the patient's home. Under the depression circumstances which now exist there are large groups who have barely enough income to live. If their illness is such as demands treatment in a hospital they have no difficulty since they can be admitted to a public ward as a charge upon the municipality. But medical care in the home for this group is difficult. Either they put off treatment because they cannot pay for it or else they are treated free by hard pressed general practitioners. There certainly is need for improvement here though a return of prosperity to Canada would greatly diminish this problem.

As far I can determine, illness which requires hospitalization is well taken care of under the present arrangements and no need for health insurance exists here. It might be argued that doctors give an undue amount of service to public ward patients for nothing and that they should receive some return for their service. This does not impress me very strongly. Certainly in large hospitals public ward service is not a great hardship, even though it does consume much time. On the contrary, it is a very considerable privilege and has many compensations. My enquiries lead me to feel that the same is true of small hospitals also.

The scheme outlined by the Canadian Medical Association in 1937 would completely swamp voluntary health insurance schemes. It would be an incalculable disaster to take away from the small income group a satisfactory means of paying their own way as far as medical services are concerned. What is needed is more voluntary health insurance schemes and in greater variety. There is an enormous group of citizens in the modest income group for whom the cost of illness could easily be financed by voluntary health insurance. I regard this as a matter of equal importance with any scheme of compulsory health insurance. The Government has already fostered old age pensions and might with equal merit foster voluntary health insurance schemes.

Dear Doctor,

I have been studying the questionnaire *re* Health Insurance issued by Dr. Wallace Wilson. I have consulted the original report which enunciated the "17 principles"—Calgary, 1934, and also the 18 principles adopted at Ottawa, 1937.

I submit to you herewith my personal conception of the reply which should be returned.

I have not discussed the matter with any member of your Committee nor with any (name of Province) Division member of the Executive C.M.A.

You are at liberty to use this in any way you see fit.

The following letter and answered questionnaire were also received from Doctor Blank:

Dear Doctor Wilson:—

Enclosed please find an answer to your questionnaire sent a month ago.

I am sorry to have waited so long in answering.

The answers, except for No. 1, are absolutely personal but I believe would be endorsed by a good number of my French Canadian confrères.

Question 1. The Canadian Medical Association, (name of Province) Division, through its Committee on Economics and its Executive Committee and representing a minority of the profession in the (name of Province) agrees:

That the time has arrived for the C.M.A. to pronounce in favour of Compulsory Health Insurance for Canada or any section thereof—provided:

1. That the enactments and regulations covering the administration of the Plan be in accordance with the basic principles adopted by the General Council of the C.M.A. meeting at Ottawa in June, 1937, and which were printed in the September, 1937, issue of the *Canadian Medical Association Journal*—with the following exceptions:—

(*a*) In order to coordinate Health Insurance enactments and regulations in adjoining areas or Provinces and to overcome those disadvantages and penalties which now accrue to self-contained Provincial enactments covering Workmen's Compensation, it is considered essential that the Dominion Government should set up a commission on Health Insurance to provide leadership to such Provincial enactments and their administration and should further provide for financial assistance to the Provinces especially in regard to the "indigent" class.

Reasons for the above opinion:

1. The C.M.A. has made an intensive study of the problem, this study extending over many years.

2. It is generally known to Governments and to the public that this study has been made and it would appear that it is but "begging the question" to defer any longer in making a pronouncement in one way or another.

3. The argument has often been advanced by ourselves that the Medical Profession should give leadership in all matters pertaining to the health of the community.

4. To come out flat in favour of Compulsory Health Insurance under certain conditions brings the profession into the strong position of being the first in possession of the field of argument.

5. To delay pronouncement until after a plan is announced by any government is to be put on the defensive.

Question 2. Not applicable.

Question 3. Declaration *for* Compulsory Health Insurance.

Question 4. Covered in answer to Question 1.

Question 5. Not applicable.

CONCLUSIONS

From a survey of the reports received the Nucleus of the Committee on Economics has felt justified in drawing certain conclusions.

I. There is not yet unanimity of opinion amongst the provincial divisions and branches concerning

(1) The "Principles" of Compulsory Health Insurance as approved by Council in 1937.

While it is true only two of the provinces made a further study of the Principles; nevertheless, both these provinces expressed themselves as not in entire accord with the Principles as they now stand and a renewed study by the other provinces might also reveal divergent opinions.

(2) What course of action the Canadian Medical Association should take with regard to defining a policy for Compulsory Health Insurance.

Did "define a policy" mean

(*a*) A declaration to the Government and the public that the Canadian Medical Association stood for Compulsory Health Insurance?

(*b*) The drawing up or drawing up and publishing or submitting to the Government a plan of Compulsory Health Insurance?

(*c*) Active study and research on the part of the Canadian Medical Association into the various problems of supplying adequate medical service to the people?

(*d*) A campaign of education of the profession and/or the public in these problems?

Possibly the wording of the questionnaire was faulty but certainly some of the answers were not of sufficient clarity to interpret to the Nucleus exactly what the Province had in mind when it answered question one.

II. With some divergence of view amongst the provinces answering the questionnaire and with some of the Boards of Directors not assuming the responsibility of answering for their Associations at the present time no mandate has been received from organized medicine in Canada for the Canadian Medical Association to take any stand for or against Compulsory Health Insurance.

III. Due in part to lack of information, there is considerable confusion of thought in the minds of the medical profession concerning the fundamentals of the various problems embraced under the term "medical economics."

RECOMMENDATIONS

1. *That the Canadian Medical Association undertake, as soon as possible, an intensive and comprehensive study of the broad field of medical economics.*

From its studies and from the information it has received the Nucleus of the Committee on Economics believes that in this work the Association would receive the support of all the Provinces.

If it is accepted that Medical Economics is a subject that ranks second to none on the present and future agenda of organized medicine in Canada, and if Medical Economics may be defined as the science that investigates the conditions and laws affecting the production, distribution, consumption and cost of the various types and kinds of Medical Services that promote and preserve the health of the people then, conceivably, it is the duty of the Canadian Medical Association to initiate a study in that field—a field of which Compulsory Health Insurance is but a part.

If the Canadian Medical Association were asked tomorrow to advise any Government on the question of a future programme in the field of Preventive Medicine is it prepared to do so? Is it prepared, on request, to advise how Preventive Medicine and any contemplated scheme of Compulsory Health Insurance should be linked up and correlated? Has the Canadian Medical Association sufficient information concerning the distribution and availability of medical services in Canada or has it digested and summarized the information available concerning costs?

It appears to your Committee that the answers to some of these questions must be in the negative and that much should and must be done to put the Canadian Medical Association house in order before inviting inspection, either from a government or the public.

Therefore, your Committee recommends that immediate steps be taken to get such a study under way. The Committee further recommends that this work be undertaken and pursued only by well qualified experts, men who by training and experience will be in a position to produce for the Association a maximum of results.

This work will cost money but your Committee respectfully suggests that it will be money well spent and that for such expenditure the Association would receive support from the provinces.

In 1910, the British Medical Association spent many thousands of pounds in a last minute drive to bolster up its case. The same thing is happening in Australia today and the Canadian Medical Association should profit by such examples.

It is the opinion of your Committee that Compulsory Health Insurance, as a Federal measure, will not enter the field of practical politics just yet. There is still time to be prepared and no excuse not to.

2. *That the Canadian Medical Association proceed at once to an active campaign of education of the medical profession in the fundamentals of medical economics.*

In some of the provinces medical economics has not been an active issue and the profession has not been interested; but in all the provinces, apart from comparatively small responsible groups, the medical men are in need of education and training in this field.

Nor is Canada alone in this. At present the Government of South Africa is preparing a draft bill of Compulsory Health Insurance and the Secretary of the South African Medical Association writes to the Chairman of your Committee—"The medical profession . . . is not quite capable yet of critizing any draft legislation. Our Federal Council is trying to interest the branches to actively consider the implications of the (Collie) report."

How best should this education of the profession be brought about?

From time to time an economic supplement to the *Journal* of the Association has been discussed but costs have always been held to be an insurmountable barrier. If such be the case, then your Committee recommends that certain deletions be made from the *Journal* so that room may be found within its present compass for a few pages devoted to "First Aids to Medical Economics." It is further recommended that a trained man be in charge of that department.

The *Canadian Medical Association Journal* does not, by any means, reach all the medical men in Canada and it is suggested to the Executive that it explore the possibility of utilizing some additional medium to reach the whole profession. The time might arrive when it might be vital to have concord, not within the ranks of the Canadian Medical Association alone but within the ranks of the whole profession and an attempt to supply information to those without the ranks of organized medicine should be considered.

So much for the written word. There should be time set aside and devoted to a study of medical economics at the Annual Meeting of the Canadian Medical Association and at the Annual Meetings of all provincial divisions and branches. The agenda of these meetings should be carefully prepared and might take the form of a symposium followed by well led round table conferences on various phases of medical economics. On occasion adequately qualified laymen might profitably be invited to address the profession.

Some years ago there was set up on paper within the Canadian Medical Association a Bureau of Economics. For a variety of good reasons this department has remained dormant. It should be awakened, revived and activated so that it may become a focus point for work in this field. If necessary, a qualified man should be put in charge.

The Bureau should then be responsible either alone or in conjunction with the Committee on Economics, for the programme on medical economics at the Annual Meeting of the Association. It should cooperate with the Divisions and Branches in arranging similar programmes for the provincial meetings and, if necessary, it should provide speakers. Finally as concerning medical economics, it should be responsible for what is published in any medium of information to the profession.

The Committee on Economics as at present constituted is too unwieldy and inconvenient a unit to undertake any or all of this work in the manner contemplated by your Committee. In the presence of an alive and active Bureau the function of the Committee on Economics might well be confined to that of advice which it would be qualified to give by virtue of its connection with the provinces through its corresponding members.

There is one other point that requires emphasis. Your Committee views with concern what appears to be, in some parts of Canada at least, a definite weakening of the ties that should intimately bind preventive and therapeutic medicine. Work in the two fields seems to be diverging rather than becoming from year to year more indissolubly fused and, at times, a lack

of sympathetic understanding as between the workers in the two compartments of the whole is apparent.

The Canadian Medical Association should endeavour to overcome and eradicate this state of affairs. It should be part of its effort to unify the profession and the practice of medicine.

For one thing preventive medicine could contribute much to both educational and constructive programmes and it should be invited to do so. For another thing, Public Health workers should be drawn more within the orbit of the activities of organized medicine as represented by the Canadian Medical Association.

Nothing has been said with reference to providing information to the public concerning Medical Economics.

Your Committee believes that in this instance charity begins at home and that if the Association is going to assume the responsibility of bestowing on any group of people the blessings of a course in Medical Economics its first thought should be the profession.

The public is in sore need of this education but an enlightened profession will be an excellent starting point. Then when information is sent out to the public the general practitioner will, it is devoutly hoped, be in a position to answer with alacrity and without undue obscurity the many questions that his patients will inevitably ask.

3. *That the Canadian Medical Association take up with the universities the question of the training of medical students in the A. B. C.'s of medical economics.*

It may be that this question is already answered by actual courses of instruction at the medical schools. Your Committee is ignorant on this point but it would like to emphasize the importance of such instruction to undergraduates in these days of social change.

Take it all in all, there is no doubt that the duty of educating the profession lies squarely on the doorstep of the Canadian Medical Association and progress along these lines is over-due.

4. *At the present time no attempt should be made by the Canadian Medical Association to draft, independently, a plan of compulsory health insurance.*

Much has been said by many doctors and laymen about the obligation of organized medicine to produce a plan of Compulsory Health Insurance.

Apart from the fact that the Canadian Medical Association should obtain approval of all the provinces in order to undertake this work and apart from the fact that all provinces would demand the right to criticize and suggest amendments with a resultant difficulty in attaining unanimity, and apart from the fact that the Association needs more information concerning conditions in Canada, there remain other definite reasons why such an action should receive very earnest consideration before being undertaken.

The question might fairly be asked "Why should the Canadian Medical Association produce a plan, particularly why should it produce a plan before a Federal Government has brought Compulsory Health Insurance within the sphere of practical politics?"

A criticism directed to the medical profession is that it waits for a Government to produce a plan and then in a highly destructive mood proceeds to tear that plan to pieces without offering another to take its place.

Organized medicine will protest the action of *any Government* in producing a "Plan" without previous consultation with the medical profession.

Is it unreasonable to assume that some members of the Cabinet which, apart from the rank and file of the Government members, is responsible for the formulating of policy might feel embarrassed and irritated at the sudden appearance of a Canadian Medical Association "Plan"?

Let this fact be clear. No scheme sponsored by the Canadian Medical Association, if it did not offer a complete medical service and if it did not include all the low income groups and the indigents, would receive the unanimous approval of the profession. Such a scheme would be expensive and cost money and, as such, would, inevitably, be attacked by sections of the public and many of the politicians.

Why should either the Government or the medical profession produce a plan at which the other side would proceed to shy cocoanuts in public?

It is the opinion of your Committee that, if and when the time comes, such a plan should be evolved jointly and without publicity by the Government and organized medicine. The argument that the Canadian Medical Association produce a plan independently should be backed by sounder reasons than that pressure is being brought to bear upon it both within and without its ranks.

It is being said at times that the Canadian Medical Association "must accept leadership", that it is "on the spot" and must "do something", "do something" being so often the demand of people who, restive under criticism, call for action even if they are unable to define that imperative mood.

What exactly is meant by the phrase "accept leadership"? Does it mean leadership of the whole of the profession by the Canadian Medical Association or leadership of the public by the Canadian Medical Association as distinct from the Government? In the latter case might not the Government as the elected representatives of the people reasonably claim the prerogative of reserving that right to themselves?

Please do not misunderstand your Committee. It is approaching this problem in no spirit of quibbling. Rather is it putting its possibly inchoate thoughts on paper as an invitation to further discussion in the hope that in the end we may think clearly.

Your Committee believes that in this matter, involving as it does so much of policy and finance, the Government must be the lead horse and that the Canadian Medical Association should be an essential and recognized running mate. It further believes that if the Canadian Medical Association were to approach the Government, particularly after further study and investigation, it could assure for itself that position. Alternately, at the outset and in the absence of any Government sponsored survey might not the Government be induced to contribute to the expenses of a Canadian Medical Association study that was shown to be comprehensive and to be undertaken by recognized experts?

5. *That no attempt be made to change or modify the principles as adopted by General Council in June, 1937, until the recommended studies and the education of the profession have been undertaken.*

In final conclusion the Nucleus of your Committee on Economics respectfully recommends that the immediate policy of the Canadian Medical Association should be—

I. The education of the medical profession in the fundamentals of medical economics.

II. The collection and study by experts of all available information in connection with the medical services of Canada so that the Canadian Medical Association may be ready when the occasion arises to

III. Seek and obtain from the Government the promise that if and when the time comes the Canadian Medical Association will be given the opportunity and the right to sit in and, adding to the common pool its knowledge and its experience in the care of the sick, help mould a satisfactory health policy for Canada.

COMPULSORY HEALTH INSURANCE

On March 7th, 1938 and again on March 6th, 1939, debates on Compulsory Health Insurance and State Medicine took place in the Federal House.

A short summary of these debates from the official report of the House of Commons debates is herewith

given in the belief that it will be of interest to those members of Council who have had to depend for their information on news items and comments in the daily press.

STATE MEDICINE—PERIODIC HEALTH EXAMINATIONS—TREATMENT FOR ALL SUFFERING FROM DISEASE

Discussions on these subjects took place in the House of Commons on March 7th, 1938, and on March 6th, 1939. Both resolutions were introduced by Mr. McIvor (Fort William) and seconded by Dr. Howden (St. Boniface).

The 1938 resolution was:—

"That, in the opinion of the House, it is most urgent that State Medicine be established in the Dominion of Canada."

The 1939 resolution was:—

"That, in the opinion of the House, the Government of Canada should try to secure amendments to the British North America Act, to provide periodical health examinations and provision for suitable treatment for all those suffering from disease."

On each occasion there was a very full discussion, members of all parties taking part in the debate.

1938—The discussion on State Medicine covered every aspect of the provision of medical treatment and at times wandered rather far afield and dealt with matters which were, to say the least, not cognate to the subject. It is obvious from the reports that the members had very widely varying opinions as to the definition of State Medicine. Dr. Howden considered it "sufficient to define State Medicine as—provision by the State or Government for the medical care of the sick." The question of jurisdiction and financial difficulties were dealt with by several members. It was generally agreed that the subject was one for which the Dominion Government could not assume full responsibility and that if they attempted to do so there would be very serious opposition on the part of some of the provinces. Most speakers seemed to agree that some scheme should be worked out whereby the Dominion Government would help to coordinate the work of the provinces and municipalities and give financial backing to the various schemes already under way. With the exception of Dr. Howden, the seconder of the resolution, all medical members who took part in the discussion were critical, and pointed out that in order to maintain medical practice at the proper high level nothing should be done which would result in regimentation of the profession and which might lead to a deadly routine, destroying the initiative of the doctor. Also nothing should be allowed to interfere with the patient's right to choose his own physician. Mr. Power, the Minister, doubted whether it would be possible at present to get assent of the provinces to the proposal that Health Insurance should be completely turned over to the Federal Government. He stated that British Columbia and Alberta would both oppose such a scheme because they have Health Insurance plans of their own. He considered that there was no doubt whatever that there is need for better medical facilities in Canada. He thought improvement could be brought about best by co-operation between all bodies, municipal, provincial and Federal and stated that the Federal Department of Health was ready and willing to do its share.

The motion was finally talked out.

1939—The discussion on the second resolution covered much the same ground with the exception that on this occasion more emphasis was laid on the value of periodic health examinations. The Minister, Mr. Power, again pointed out that all the Federal Government could do, would be to co-operate with the provincial authorities. He considered that periodic examinations would be of great benefit but that the cost would be almost prohibitive and the only practical way of carrying this out would be as part of some wider scheme for Health Insurance. He also contended that the resolution as drafted would not be of any great value and that if anything worthwhile were done it must be by coordinating the efforts of the Dominion with those of the provinces and on a much wider scale than that which now obtains. He thought that when the provinces had themselves coordinated their efforts and that when they came to the Federal authority for help, that pressure throughout the country would be such that the Federal authority would be obliged to give leadership in effecting a definite health programme.

He said further—

"It seems to me that the way to settle this matter definitely and to have a clear programme which could be presented to the Canadian people, would be by some kind of health conference at which there would be present representatives not only of the provinces as such, but of social agencies interested in this kind of thing throughout the country, of medical associations, at which conference the particular interests of the provinces, of the Dominion, of the medical associations and even of the welfare agencies, would be to some extent set aside so that it would be possible, without prejudice, to determine what is needed as a beginning for the carrying out of our plan."

In conclusion he said:—

"I propose to repeat what I said last year, that my personal view is that State Medicine, as such, will not, for at least some little time, be generally accepted by the Canadian people. I feel that there is in it too much regulation and regimentation to make it acceptable to the people of this country. But I also feel that some form of Contributory Health Insurance will have to be studied; and not only studied but put into operation in conjunction and co-operation with the provinces before very long."

This motion was also talked out.

Speaking before the Health League of Canada at a dinner held in Toronto on Saturday, April 22nd, 1939, the Honourable C. G. Power, Minister of Pensions and National Health, had the following to say in relation to State Medicine and Health Insurance:

"It is possible—probable in fact—that we will have State Health Insurance in Canada on a contributory basis. Every citizen realizes that he is entitled to protection from disease just as the police protect his property. Whatever form it takes, the scheme will make it possible for the poorest citizen to receive the utmost in treatment and hospital care. I mention State Medicine to many doctors and find they have different meanings for it. Some think it includes complete state controlled medical, dental and hospital care. It would make of every medical man and nurse an employee of the State. Only one country in the world has achieved that degree of State Medicine and we do not know yet what its value has been. I doubt very much if it will ever be possible to bring about such conditions as those in our country, in our time. We do not believe in regimentation to that extent; but Health Insurance is something quite dissimilar to State Medicine.

"Already three Canadian provinces, namely, British Columbia, Alberta and Saskatchewan have adopted measures of a Health Insurance character. Thirty-four nations have adopted Health Insurance. In England, Health Insurance embraces 19,000,000 persons, and in Germany, 20,000,000 persons. New Zealand and Australia have recently completed plans for Health Insurance. Throughout almost every country, we already have some form of social insurance, and Canada cannot lag behind. It is difficult to say if it could be done under our present constitutional set-up; but surely some arrangement between local, provincial and federal authorities could be worked out. When we have arranged the constitutional difficulties, a great many of our health difficulties will disappear."

The Honourable Minister went on to say that private initiative could do as much towards a national

health scheme as the Government, although the high cost of research almost inevitably dumped a part of the problem into the Government's lap.

He continued,—"The private citizen, finding the State taking over more and more duties, is inclined to give less of his own money; but short of State Medicine, it will be impossible to do away with the assistance given by the citizens to the State in the development of a health programme."

While Compulsory Health Insurance has not yet emerged as an active issue in Federal politics in Canada the same cannot be said concerning some other members of the British Commonwealth of Nations.

In South Africa preparations are being made to attempt to solve the problem. In Australia and New Zealand the Federal Governments are urgently demanding a solution but have not yet reached an understanding with their medical professions.

The Committee on Medical Economics, in the hope that information concerning Compulsory Health Insurance in these Dominions would be of interest and value to members of Council, has been fortunate in obtaining the cooperation of the Secretaries of the branches of the British Medical Association in Australia, New Zealand and South Africa. The members of the Committee on Medical Economics are grateful to Dr. J. G. Hunter of Australia, Dr. P. P. Lynch of New Zealand and Dr. C. L. Leipoldt of South Africa for the great amount of time and work they have devoted to answering the questions submitted by the Committee on Economics. It is they who have made possible the presentation to Council of the following reports and these reports are submitted in the hope that Canadian medicine may be better informed concerning the difficulties confronting the medical profession in other Dominions, especially in Australia and New Zealand.

AUSTRALIA

Accompanying Dr. Hunter's report were numerous detailed appendices to which he refers from time to time. Many of these appendices were lengthy documents and it was found impossible to include them *in toto* in this report to Council. The Committee on Economics has, therefore, made brief summaries of some of them which summaries will be found at the end of Dr. Hunter's memorandum.

Wallace Wilson, M.D.,
Chairman, Committee on Economics, C.M.A.,
203, Medical Dental Building,
Vancouver, B.C.

Dear Sir,

At the request of Dr. Lindsay Dey, I am forwarding to you a copy of the National Health and Pensions Insurance Act, 1938, together with some information regarding National Insurance in Australia, which I trust may be of assistance to you.

1.—*The History of National Health Insurance in Australia.*

In 1924 the Commonwealth Government appointed a Royal Commission on National Insurance. The first Progress Report of the Commission was issued early in 1925 and was produced *in extenso* in the *Medical Journal of Australia* in that year.

The second Progress Report dealt with Unemployment, and the third on Destitute Allowances. The final report dealt with Membership, Finance and Administration and was published in the *Medical Journal of Australia*, 1927, Vols. I and II.

The Federal Committee of the British Medical Association in Australia was asked to draw up a constructive scheme of National Health Insurance. Before agreeing to do so, the Committee deemed it wise to ascertain the attitude of the profession throughout Australia towards National Insurance. With that object, a questionnaire was submitted to the Members of the Branches in the several States. As so often happens, no great interest was taken by the profession in the matter, but of those who replied a great majority were opposed to the introduction of any form of compulsory medical benefit. The Federal Committee informed the Royal Commission on National Insurance to that effect. It added, however, that it was continuing its investigations of the subject, with the object, if possible, of formulating some constructive scheme which would be acceptable.

The Committee subsequently submitted the following proposals to the Councils of the Australian Branches of the Association as a basis on which an acceptable scheme of National Health Insurance might be built up, *viz.*: (*Vide* Appendix "A").

The Royal Commission, however, deliberately refrained from including medical benefit in its system of insurance, and the Bill which was brought down by the Commonwealth Government did not include medical benefits—simply old age and pension benefits and sickness benefits, the co-operation of the profession being sought in regard to certification for the latter benefit.

The Bill, however, was dropped, and nothing further was heard of National Insurance until 1935, when the Commonwealth Government announced its intention of inviting Sir Walter Kinnear, Controller of Insurance Department, Ministry of Health, England, to visit Australia and assist the Commonwealth in its investigations on the subject of a National scheme of insurance for health and pensions.

Sir Walter arrived in Australia in August, 1936, returning to England towards the end of October. I am enclosing a copy of his report, which I shall be glad if you will return in due course. (*Vide* Appendix "B").

I may say that beyond a casual conversation with a few members of the profession, Sir Walter did not consult with the profession regarding the difficulties associated with medical practice in this country as compared with England.

The Federal Council (formerly the Federal Committee) had not been idle all this time, and a special Committee was appointed to consider the whole question of National Insurance. The Report of that Committee it attached. (*Vide* Appendix "C").

A letter was addressed to the Prime Minister setting out what the Association in Australia considered should be essential factors of any scheme of compulsory health insurance introduced by the Government. (*Vide* Appendix "D").

The next stage in the developments was an announcement by the Government that it proposed again to invite Sir Walter Kinnear to Australia at the beginning of 1938 in order to further the proposals of the Government in regard to a National scheme of insurance.

Shortly after Sir Walter's arrival in Australia early in 1938, the Federal Council was requested by the Commonwealth Government to meet him and representatives of the Government in regard to the medical benefits which the Government proposed to introduce in the Bill that was to be brought before the House some time in April. The representatives of the Federal Council met Sir Walter and his colleagues and the whole question of payment for services was discussed. Enclosed is a copy of notes made in the discussions between Sir Walter and the members of the Federal Council (*Vide* Appendix "E").

At the conclusion of these conferences, the following decisions were made, and the President of the Federal Council (Sir Henry Newland) informed Sir Walter Kinnear that these decisions would be submitted to the profession as a whole, it having been made quite clear by Sir Henry that the profession was not bound to accept them. (*Vide* Appendix "F").

Up till this time, very little interest had been taken by the profession generally in the whole question of National Insurance, but when the decisions were announced, the profession awoke to the fact that

National Insurance was a real live issue, and active opposition to the whole thing began. The terms offered by the Commonwealth were severely criticized, and the profession as a whole made it quite clear that they were not prepared to accept them. It was, therefore, the duty of the Federal Council to inform the Government that this was so, and a letter was sent to the Treasurer, the Minister in Charge of the National Health Insurance Bill (Mr. R. G. Casey) (*Vide* Appendix "G").

The chief objections to the Bill, as originally introduced were:

1. The control of medical benefits by lay persons.
2. The power of the Insurance Commission in regard to regulations (*i.e.* bureaucratic control).
3. The inadequate payment.

Representations were made to the government in regard to these matters, but without avail, and, despite the protests of the profession, the Bill was forced through both Houses in April.

However, in view of the opposition to the Bill and the turning down of the decisions made at the conference with Sir Walter Kinnear, the Commonwealth Government decided to appoint a Royal Commission.

Unfortunately, the terms of the Royal Commission, a copy of which is attached (*Vide* Appendix "H") deal practically only with the question of payment and not with the question of control or standard of service, a point which we have so strongly emphasized.

The Association decided that it should be represented before the Commission and should submit evidence. The Commission commenced taking evidence early in August, and travelled round Australia taking evidence from medical practitioners and other persons in each State. No doubt you have followed the reports of the Commission's sittings in the *Medical Journal of Australia*.

A tragic air accident resulted in the Association losing the whole of its legal advisers, four in all, and its accountant, with consequent delay in the sittings of the Commission. Subsequently, the Chairman of the Royal Commission, Chief Judge Detheridge, took ill and later died, with the result that the Commission was still further delayed. The final sittings of the Commission will probably take place about the end of this month, and its report will probably be published some time in March.

In the meantime, the opposition of the profession has steadily developed, until now there is very general opposition throughout Australia to the Act, and it will require some drastic changes before the profession will accept service.

Strangely enough, too, there is developing opposition in other quarters, and many interests are now opposed to the implementation of the Act, particularly in view of the heavy expenditure being incurred by the Government in Defence matters. The Government has decided to delay the collecting of contributions until September 1, 1939, and it would not be surprising if there were still further delay.

2.—*The Chief Features of the Present Act (Medical Benefits).*

The chief features (medical benefits) of the present Act, you will note, are (*Vide* copy of Act, Appendix "I"):

1. That the administration is placed in the hands of a Commission of three. At the present moment, of the three Commissioners one is an economist, one is a statistician, and one a Government administrator, a public servant, the medical profession not being represented, so that the final say in regard to the question of medical benefit lies with a lay body

2. The unemployed and the unemployable and their dependents are not insured.

3. Medical benefit consists of such proper and necessary medical services as are prescribed. Although no such benefits have been yet officially prescribed, the scope of service to be rendered by practitioners is as follows (See Appendix "J").

4. There is a wage limit of £365 p.a. but not an income limit, meaning, of course, that even though a person may have as much as £1,000 p.a. private income, he would still be an insured person if the wages he received were less than £365 p.a.

3.—*Was the Profession Called in in Consultation in the Planning and Writing of the Act?*

I have already indicated that when Sir Walter Kinnear visited Australia, beyond a cursory talk with a few members of the profession, he did not consult the profession generally, nor was the profession consulted by the Government in the drafting of the Act, in fact the amendments that have been suggested by the profession have been consistently turned down. Had the Government consulted the bodies likely to be affected by the Act, there would certainly have been less opposition to it.

4.—*How Will the Act Affect Private Practice?*

This is the question which most seriously concerns the members of the profession. At the present time in Australia there are approximately 600,000 wage earners with their dependents receiving medical benefits through contract practice. These persons are, by far the greater part, members of Friendly Society Lodges. Of these 600,000, approximately 400,000 will become insured persons. The remaining 200,000 such as small shop keepers, and farmers, who are not entitled to benefits under the Act, will still receive their medical benefits from the Friendly Societies. The total number of insured persons is estimated to be 1,850,000, so that the Act will result in taking from private practice 1,450,000 persons, who on the average, pay to a medical practitioner a private fee of somewhere between 7/- and 10/-, and who, as insured persons will probably pay an average fee of about 2/3d., if the Government still maintains its offer of 11/- per insured person (this estimate for each insured person will require approximately four services per year).

In presenting our case to the Royal Commission, we have tried to show the serious effect that the Act will have on the private practice of members of the profession by the transference of this big number of private patients to the insured class, and, whilst it is true that the Act is not one to recompense or compensate doctors for loss of practice, at the same time, if medical practitioners are to secure a reasonable income to enable them to maintain their present status in society, the capitation rate must be such that they will not suffer in loss of income as the result of the transference of private patients to the insured class.

The problem is not an easy one to solve, but, from the evidence of our witnesses and from the replies to questionnaires sent out to members of the profession, it would appear that, in order to prevent loss of income by the profession generally, a capitation rate of somewhere between 19/- and £1 is necessary.

The percentage of breadwinners in this country with incomes of over £365 p.a. is not very great, so that there would be relatively a very small proportion of the population left in the private class.

5.—*Will the Act do all for the People that the Government Thinks it Will?*

It may be stated that the real reason for the introduction of the present Act was to enable the Government to cope with the ever-increasing cost of Old Age Pensions; health insurance paying a subsidiary part.

Despite the findings of the Royal Commission in 1926, the Government embodied the plan of a partial health service in the same Act as the pensions service. In so doing, it is considered that the Government committed a fundamental error, for there is no essential relationship between a health service and a pensions scheme. Health service demands a highly

technical administration, untrammeled by manifold regulations, while pensions administration requires close regulation and financial control. It is inevitable that, where two purposes are sought to be achieved by the one administration, the demands of financial control over-ride the technical needs of a health service to the great detriment to the public health.

Instead of consulting with local authorities on the vital principles of a health service, the Government from beginning to end relied on the advice of an overseas insurance expert who, unfamiliar with Australian methods, Australian psychology and exigencies incurred by Australian geography, sought to establish on an Australian background, a replica of the British Health Insurance Scheme. The standard of medical service in Australia in 1938 was manifestly quite different from that in Great Britain in 1911.

What the Government expects the scheme to do for the people, no one knows, but it is the belief of the profession that, if not less, it will certainly do no more than what is being done for the people by the existing methods.

6.—*What is the Attitude of the Profession to the Act in General, Apart from the Question of Remuneration?*

I have already indicated that the profession is entirely opposed to the method of control, and, further, it contends that the persons who most need medical benefits and are least able to secure them, namely the unemployed and unemployable, are not included in the Act, nor are the dependents of insured persons. There is always opposition to any State controlled services, but those are questions which, of course, largely depend on the method of administration and control.

7.—*Are They Prepared to Work it if the Commission Recommends and the Government Agrees to an Increase in Capitation Fee?*

The answer is *NO*, unless there are drastic changes in control and administration.

8.—*Will the Act do Anything for Preventive Medicine?*

This, on the face of it, is a somewhat difficult question to answer. Theoretically, the fact that persons are insured and able to get medical benefits should go a long way towards prevention of disease, but will it do any more than is being done at the present time or under present conditions? Disease prevention does not lie entirely within the province of the medical practitioner. There are so many other social and economic factors connected with it. Certainly the Government has not indicated in any way how the medical benefits provided under the Act will assist preventive medicine.

Faithfully yours,

J. G. HUNTER,
General Secretary.

APPENDIX "A"

PROPOSALS OF AUSTRALIAN MEDICAL ASSOCIATION

1. (*a*) All persons below income limit to be included;
   (*b*) All accidents and all sickness included:
   (*c*) Representation of medical profession.

All sickness, including Tuberculosis, Alcohol, Venereal Diseases, etc.; Indigents, unemployed, low wage earner, pensioners, all to be included.

2. Free choice of doctor.
3. Medical benefit to give general practitioner service and to be capable of extension so as to include—

   Specialists,
   Hospitals,
   Diagnostic Aids,
   Consultations,
   Maternity benefit,
   Dentistry.

   All these to be eventually part of the full scheme.

4. Scale of fees as method of payment—
   Payment the same for all, that is for those contributing and those not contributing.

Note—(This appears to have been modified in later communications to allow of a system calling for capitation fees or flat rate.)

APPENDIX "B"

SIR WALTER KINNEAR'S REPORT

Reviews status of Health Insurance and agrees that it should be contributory and compulsory and limited to the wage earning population (dependents excluded).

It describes the system in Great Britain and then proceeds to elaborate in detail a plan for Australia that is almost a counterpart of the British one but is also linked up with a widows, orphans and old age contributory pensions scheme.

APPENDIX "C"

REPORT BY FEDERAL COUNCIL OF AUSTRALIAN MEDICAL ASSOCIATION ON MEDICAL PROFESSION'S VIEWS

1. Friendly societies should be excluded for medical benefits.
2. Administration—Income limit, etc.
3. Benefits should include:

   Hospital,
   Clinical Aids,
   Specialists,
   Special treatments (*i.e.* physiotherapy, etc.),
   Consultations,
   Maternity.

4. Differences between British system and that suggested by Federal Committee discussed.
   Scope of those eligible.
   Payment by fee.

This appendix also refers to the urgent necessity for preventive medicine.

Points out that in countries which have Health Insurance Acts, various methods of payment are adopted:

(*a*) Salary,
(*b*) Capitation,
(*c*) Straight fee list,
(*d*) Pro rata payment from pool,
(*e*) Patient pays direct and is reimbursed from a fund.

Urges—

(1) Post graduate instruction for medical men engaged;
(2) Close coordination with public health services;
(3) Creation of a Medical Research Council;
(4) Separation of medical benefits from sickness insurance benefits;
(5) Deals with records, certificates, discipline, etc.

APPENDIX "D"

This letter to the Prime Minister enclosed the report adopted by Federal Council of the Australian Medical Association and referred to here as Appendix "C".

It stated, in addition, what the profession considered to be certain basic principles and accepted the principle of the capitation system of payment.

APPENDIX "E"

These are full and detailed notes made at the discussion with Sir Walter Kinnear. They cover many phases and details of the proposed Health Insurance Scheme such as—

Income limit,
Scope of medical benefit,
Remunerations and mileage,
Administration details,
Instructions to beneficiaries and doctors, etc., etc.

APPENDIX "F"

BRITISH MEDICAL ASSOCIATION
New South Wales Branch
British Medical Association House,
135 Macquarie Street,
Sydney, 14 April, 1938.

MEDICAL BENEFIT UNDER THE NATIONAL HEALTH INSURANCE SCHEME

The arrangements for the provision of medical treatment to persons insured under the proposed national health insurance scheme have been discussed by the Federal Treasurer and Commonwealth officers with the Federal Council of the British Medical Association, and agreement has been reached on the following lines:

1. The service to be provided under the national scheme will be provided for insured persons only and not for any dependents of insured persons. The service will be a general practitioner service, excluding treatment in respect of a confinement, treatment of injuries or disease in respect of which the insured person is entitled to benefit under the Workers' Compensation Acts, major operations and the administration of an inhalant anæsthetic. Minor operations and the treatment of fractures and dislocations will be included.

2. The payment to be made to insurance doctors for this service will be at the rate of eleven shillings per annum for each insured person entitled to medical benefit under the national scheme. Specialist services, major operations and the administration of inhalant anæsthetics are to be paid for by the insured person under conditions to be determined. To meet the special difficulties of country doctors, additional payments will be made by the commission for mileage, to cover both travelling expenses and time, in respect of each insured person resident in country districts more than three miles from the nearest insurance doctor, on the basis of two shillings per mile, one way, of each mile over three of the distance between the insured person and the nearest doctor. The payments will be based on the actual numbers and distances of the persons on each country doctors list.

3. The Insurance Commission will be assisted in the administration of medical benefit by a central medical benefit council, for general matters of policy, and by district medical commissioners, for individual questions of detail, on both of which insurance doctors will have substantial representation.

Any legally qualified medical practitioner will be admitted to the scheme, and none can be removed from the service except after inquiry by a tribunal of two medical practitioners with a legal chairman. Corresponding safeguards will be provided for insurance doctors in respect of minor disputes.

Insured persons will have free choice of doctor among those included in the service.

4. The arrangements agreed provide for consultation with the medical profession in formulating the details of the scheme.

It is estimated that the scheme will cover about 1,850,000 wage-earners.

Further particulars of the proposals relating to medical benefit will be made available at a later stage.

APPENDIX "G"

LETTER SENT TO MINISTER IN CHARGE OF THE NATIONAL HEALTH INSURANCE BILL BY FEDERAL COUNCIL OF THE AUSTRALIAN MEDICAL ASSOCIATION AND RAISING OBJECTIONS TO SCHEME AS BEING QUITE UNSATISFACTORY IN MANY PARTICULARS

1. Capitation fee—quite inadequate; should be at least $3.50; with 25 per cent additional for country areas.

2. Mileage—should be at least 60 cents; 12 cents payable by patient, as deterrent; 2 miles the radius.

3. Night Calls—there should be a fee.

4. Services to be excluded: Anæsthetics, acute alcoholism and venereal diseases, fractures and dislocations except very simple ones, premature births, miscarriages and abortions.

Specialist service—pool should be set up to provide x-ray, etc.

APPENDIX "H"

NATIONAL HEALTH AND PENSIONS INSURANCE ACT, 1938 —ROYAL COMMISSION—TERMS OF REFERENCE

1. The annual sum of money per insured person to be paid to insurance medical practitioners in all areas where medical benefit becomes available, which the National Insurance Commission should provide under the National Health and Pensions Insurance Act, 1938 (excluding amounts otherwise to be provided in respect of extra travelling in country districts), having regard to the scope of the treatment to be provided under that Act and to the terms and conditions of existing contract practice in Australia, and other relevant considerations.

2. The methods of distributing among insurance medical practitioners the total amount provided under paragraph 1, having regard to the treatment required by insured persons when away from their homes.

3. The annual sums to be provided by the National Insurance Commission in respect of insured persons resident more than three miles from the nearest insurance medical practitioner for payment to such practitioners towards the cost of travelling and the time spent in travelling.

4. The methods of distributing among insurance medical practitioners the total amount provided under paragraph 3.

5. The circumstances and conditions under which insurance medical practitioners may require payments from insured persons in respect of services rendered in pursuance of the National Insurance Act or in respect of services rendered otherwise than in pursuance of the National Insurance Act.

6. The appropriate annual sum of money to be paid under contract to medical practitioners by organizations which may provide on a voluntary basis for the treatment of the wives and children of insured persons, having regard to the terms of existing contract practice in Australia, and to the amount recommended under paragraph 1.

7. The conditions under which medical practitioners who enter into contracts for the medical treatment of the wives and children of insured persons may require payment for services outside the terms of their contracts.

8. The minimum period to which the recommendations of the Royal Commission should apply.

APPENDIX "J"

DEFINES GENERAL MEDICAL PRACTITIONER SERVICE

Excludes—Anæsthetics, confinements, compensation work, insured accident cases—*e.g.*, motor accidents, venereal disease, x-rays—pathology, consultations, amputations, complicated fractures, major operations, specialist care.

Medical Benefit consisting of attendance on, and treatment of, the insured person by a duly qualified medical practitioner, and should include all proper and necessary medical services other than treatment in respect of a confinement, and other than treatment involving the application of special skill and experience of a degree or kind which general practitioners as a class could not reasonably be expected to possess. Treatment should include the issue of necessary medi-

cal certificates and the keeping and furnishing of any necessary records and reports;

Medical benefit including the supply of proper and sufficient drugs and medicines and prescribed appliances to insured persons by registered chemists or pharmacists, or, in exceptional circumstances, by medical practitioners.

HEALTH INSURANCE ABANDONED

Since the above report was received the following note has been published from its Australian correspondent in the issue of the *Lancet* of April 1st, 1939:—

"The federal government has now decided to abandon completely its national-insurance scheme. In a desperate attempt to preserve the plan, even if only in skeleton form, several less comprehensive schemes were considered, but a clear majority of the cabinet favoured the complete abandonment of the act. This decision was understood to have been come to, first, because of fear that the financial burden involved might stifle normal developmental expenditure if it fell simultaneously with the heavy defence programme and while the greater part of the Commonwealth is suffering from the effects of severe drought and widespread bush-fires; and secondly, because the act is highly unpopular throughout Australia, and its introduction against the wishes of the people might lead to grave political consequences. The opposition to the scheme in the ministry itself, though strong when parliament adjourned in December, has increased immensely since. In the past two months members of the cabinet have moved freely in their electorates and have been astonished at the intensity of public feeling against national insurance. The abandonment of the scheme will render useless the considerable sums already spent on organization and administration. Already 156 approved societies have been formed, 60 by trade-unions, 59 by friendly societies and 37 by miscellaneous organizations. These societies have incurred heavy expenditures in providing office accommodation and furnishings, in anticipation of the full operation of national insurance in September, and many men have left lucrative positions to take administrative posts with the societies. It is to be hoped that it will be possible to introduce a modified scheme when the nation is better prepared to handle developmental measures."

NEW ZEALAND

The following memorandum with reference to Health Services in New Zealand is divided into four parts.

The first section has been made possible through the courtesy of Dr. M. H. Watt, Director General of Health for New Zealand, and is a very brief outline of Public Health Administration in that Dominion.

The second section is a synopsis of the benefits that are to be obtainable under the Social Security Act of 1938.

The next section is a communication from Dr. P. P. Lynch, Honorary General Secretary of the British Medical Association—New Zealand Branch, setting forth the attitude of the medical profession to the scope of the medical benefits under the Act.

The last section is a brief summary of the main provisions in the plan of Health Insurance submitted to the Government by the medical profession.

PUBLIC HEALTH SERVICES IN NEW ZEALAND

In 1920 the present Health Act was passed which consolidated the public health services under one administration and at present the Department administers the following Acts:

(*a*)
1. Health Act, 1920.
2. Hospitals and Charitable Institutions Act, 1926.
3. Food and Drugs Act, 1908.
4. Dangerous Drugs Act, 1927.
5. Poisons Act, 1934.
6. Nurses and Midwives Registration Act, 1925.
7. Medical Practitioners Act, 1914.
8. Medical Act, 1908.
9. Masseurs Registration Act, 1920.
10. Plumbers Registration Act, 1912.
11. Opticians Act, 1928.
12. Dentists Act, 1936.
13. Quackery Prevention Act, 1908.
14. Cemeteries Act, 1908.
15. Social Hygiene Act, 1917.

(*b*) Under the Health Act, 1920, control of health matters was vested in the Department of Health. A Board of Health was appointed under the chairmanship of the Minister, consisting of representatives of the Department, the medical profession, the Faculty of Medicine in the University of Otago, the Municipal Association, the Counties Association, Hospital Boards, and Civil Engineers, together with a representative of the interests of women and children.

(*c*) The functions of the Department of Health are set out in Section 12 of the Health Act, which reads as follows:—

"12. Functions of Department of Health—The functions of the Department of Health shall be—

(*a*) To administer this Act and all other public Acts in so far as their purpose is the promotion of health;

(*b*) To advise local authorities in matters relating to public health in so far as those local authorities are charged with the care of the public health by this or any other Act;

(*c*) The prevention, limitation and suppression of infectious and other diseases;

(*d*) To promote and carry out researches and investigations in relation to matters concerning the public health and the prevention or treatment of disease;

(*e*) To publish reports, information and advice concerning the public health;

(*f*) The organization and control of medical, dental and nursing services, so far as such services are paid for out of public monies;

(*g*) Generally, to take all such steps as may be desirable to secure the preparation, effective carrying out, and coordination of measures conducive to the public health."

The public health administration is largely vested in the Central Government and the staff of the Department is headed by the Director General of Health with various Divisional Directors under him. The Dominion is divided into thirteen health districts, each of which is under the charge of a medical officer of health who has had special training in sanitary science.

The New Zealand Department of Health is also responsible for the administration of the Hospital System of the Dominion. There are at present 42 hospital districts which are governed by Hospital Boards representing the various contributory districts.

DUTIES OF HOSPITAL BOARDS

Subject to inspection and a modicum of Government control the Hospital Board is responsible for the provision of public hospital care, outdoor medical treatment and nursing service and for the administration of charitable relief.

It is the duty of the Board to establish such hospitals as may be deemed necessary (excepting mental hospitals), to appoint the necessary medical, dental and nursing staffs, and administer the hospitals generally, subject to certain Government control and inspection.

Every Hospital Board is also responsible for the administration of charitable aid within its districts, whether indoor or outdoor relief and is empowered to provide grants of money, food, medicines, disinfectants, surgical requisites, medical, surgical or nursing attendance and other requisites to indigent, sick or infirm persons in the district. A Hospital Board is also empowered to make grants or subsidies to medical or nursing associations, benevolent institutions, or private philanthropic associations, as the Minister approves.

FINANCES OF HOSPITAL BOARDS

The principal sources of revenue of Hospital Boards are patients' fees, constituting about one-fifth of the total receipts, contributions by local authorities approximating two-fifths, and Government subsidies approximating two-fifths.

Each year the Boards submit to the Minister the net estimated expenditure for the coming year. The Minister of Finance apportions to each contributory local authority the amount which they will have to raise and they may raise it in such a manner as they see fit. There is a right of appeal by local authorities if they consider the levy excessive, but if the local authorities do not pay, the Hospital Board may recover in Court. Subsidies for capital expenditure are granted by the Government at the rate of £1 for every £1 contribution from local authorities.

In the staffing of the New Zealand Hospitals there is no uniformity. Some hospitals are staffed by full-time salaried medical officers. In others the majority of the staff are honorary visiting doctors supplemented by a limited number of full-time salaried medical officers—others again, have part-time paid visiting medical officers, supplemented by a full-time resident staff.

SOCIAL SECURITY ACT

The most interesting development in the medical history of New Zealand was the passing of the Social Security Act 1938, to become operative April 1st, 1939.

Subject to certain resident and income qualifications the following are the Social Security benefits. Generally speaking, qualifications are ten years' residence in New Zealand previous to the passing of the Act and allowable income about equal to the amount of the benefit. Health benefits are not subject to these commutations.

SOCIAL SECURITY BENEFITS

Superannuation

	£	s.	d.	
Age Benefits	1	10	0	a week
Universal Superannuation (from 1st April, 1940), £10 a year rising to	78	0	0	a year

Invalids' Benefits

Invalid with dependents	1	10	0	a week
Wife	0	10	0	"
Each child	0	10	0	"
Married woman	1	10	0	"
Invalid under 21 without dependents	1	0	0	"
Invalid over 21 without dependents	1	10	0	"

Widows' Benefits

With children under 16				
Widow	1	5	0	"
Each child	0	10	0	"
Without children under 16	1	0	0	"
Other widows who qualify	1	0	0	"

Orphans

Up to	0	15	0	"

Family Benefits

For each child after the first two under 16	0	4	0	"

Miners' Benefits

	£	s.	d.	
Miner	1	10	0	a week
Wife	0	10	0	"
Each child	0	10	0	"

Sickness Benefits

Sick person 16 to 20 without dependents	0	10	0	"
Others over 16	1	0	0	"
Wife	0	15	0	"
Each child	0	5	0	"

Unemployment Benefits

Unemployed person 16 to 20 without dependents	0	10	0	"
Others over 16	1	0	0	"
Wife	0	15	0	"
Each child	0	5	0	"
Maori War Benefits	1	10	0	"
Emergency Benefits	According to circumstances			

Health Benefits—For all residents of New Zealand regardless of income. (To become operative on 1st April, 1939, or as soon after that date as arrangements can be made.)

Medical Benefits—Full general practitioner services; free choice of doctors; right of all doctors to participate; relationship between doctor and patient safeguarded.

Pharmaceutical Benefits—Supply of all necessary drugs and medicines; supply of prescribed appliances and materials; right of all chemists to participate.

Hospital Benefits—Free treatment in public hospitals; partial payment of private hospital charges; clinical and other out-patient services; free treatment in State mental hospitals.

Maternity Benefits—Free treatment in public maternity hospitals; payment of major proportion of fees of private maternity hospitals; services of doctor, midwife, and maternity nurse; ante-natal and post-natal treatment; free choice of doctor, midwife, nurse, and maternity hospital; rights of all doctors, midwives, nurses and hospitals to participate.

Supplementary Benefits—(To become operative when provision can be made); home nursing and domestic assistance; services of specialists and consultants; radiological and laboratory services; dental services; ambulance services.

War Pensions—(Under Finance Act, 1938)—
Economic pension, £1 10s. a week.
War veteran's allowance, £1 5s. to £1 10s. a week.
Wife, 15s. to £1 a week.
Each child, 5s. a week.
Maximum allowance, £3 to £3 10s. a week.

It will be seen from this bare outline the very wide scope of this Act. In the words of the Prime Minister, Honourable M. J. Savage,—"In the Social Security Act an attempt has been made for the first time to provide as generously as possible for all persons who have been deprived of the power to obtain a reasonable livelihood through age, illness, unemployment, widowhood or other misfortune."

BRITISH MEDICAL ASSOCIATION

NEW ZEALAND BRANCH

Wellington, February 10th, 1939

Dr. W. Wilson,
203 Medical Dental Building,
Vancouver, B.C.

Dear Dr. Wilson,

I have to thank you for your letter of December 20th, in regard to Health Insurance.

I have been asked to convey to you the hearty thanks of this Association for the very valuable and comprehensive survey of the progress of Health Insur-

ance in British Columbia and Canada as a whole. We will probably make your report available to our members as there are many points in it which will give them valuable information and also encouragement.

I have submitted your letter and report to Dr. J. P. S. Jamieson, who is at the present time the president of the Branch, and who is also the permanent Chairman of the National Health Insurance Committee. With his assistance I have prepared the attached summary of the situation in New Zealand in regard to Health Insurance.

I have tried, as far as possible, to reply to the questions specially mentioned in your letter and although I have not replied to them *seriatim*, I think all the points mentioned in your questions are contained in the summary submitted.

I hope this brief report will be as valuable to you as yours has proved to be to us.

We send our best wishes to our colleagues in Canada,

Yours faithfully,

P. P. Lynch,
Hon. General Secretary.

HEALTH INSURANCE IN NEW ZEALAND

DR. LYNCH'S MEMORANDUM

For some years past in New Zealand proposals to establish some form of Health Insurance have been part of the pre-election campaigns of all political parties.

In 1934 the then Coalition Government (The Right Hon. G. W. Forbes, Prime Minister) set up a department committee to study the question and make recommendations. We understand that this committee recommended a partial and modified Health Insurance scheme on lines similar to the British scheme, that is, to cover employed persons only and with no provision made for dependents of employed persons or the indigent.

At about the same time the Hospital Boards Association, after a review of the Health Insurance systems in various countries throughout the world, prepared a scheme for the purposes of discussion, again following the same lines and suggesting an income limit of £250; the proposed remuneration for practitioners for general practitioner services was 12/6 per capita.

Then, in February, 1935, on account of the interest shown by political parties, the Government and the Hospital Boards, the New Zealand Branch of the British Medical Association set up a special committee for the purpose of investigating the question of National Health Insurance and reporting to the Association. This Committee has been at work ever since. The first duty undertaken was to obtain all possible information regarding the systems in other countries and disseminate the information amongst its members. In this part of its work there was found to be no more valuable source of information than the plan which had been prepared by the Canadian Medical Association.

Subsequently, it was discussed in what way a system could be adapted to the special conditions of New Zealand and the conclusions of the Committee were that in the special conditions of this country a Health Insurance system was less required than in any other part of the world on account of the facilities already in existence to meet difficulties of people of lesser means; but it was considered that for this country the introduction of a system that would give the completest possible medical service to those of low incomes (less than £250 per annum) was all that was necessary.

In December, 1936, a Labour Government (The Right Hon. M. J. Savage, Prime Minister) was elected to office for the first time and in September, 1937, an investigation committee was set up by the Government. This Committee, in the opinion of the profession, was not in any way qualified for the important task allotted to it. It consisted of seven members of the House of Representatives, all belonging to the Labour Party—they were, in fact, the Labour members of the Health Committee of the House of Representatives. A Socialist doctor was the chairman of this committee. The conclusions and recommendations of this committee appear to have had an important influence on the subsequent policy of the Government.

In the beginning, this committee issued a questionnaire to all interested bodies, including the British Medical Association, ostensibly in order to obtain information and opinion in regard to the establishment of a system. This investigation committee presented a report to the Government but it appeared to have been little influenced by the evidence submitted to it. It recommended the establishment of a free *universal* general practitioner service, free hospital service, free maternity service and free medical supplies for all, irrespective of income. This report was submitted to the Minister of Health about October, 1937. It was never published and has never been made available to this Association and its contents are to be inferred only by the subsequent course of events.

The Association had already presented its plan to the Government, the plan of which you already have a copy, but it received such scant consideration from the Government that it was found some five months later, that the two Ministers chiefly concerned were unacquainted with its contents.

At the beginning of April, 1938, the Prime Minister broadcast a résumé of the projected Social Security Legislation which included proposals for establishing a National Health Insurance system along the lines which had obviously been submitted by the investigation committee and completely ignoring the recommendations of the medical profession. At the same time the Prime Minister announced the setting up of a Parliamentary select committee to receive representations from anyone who wished to do so with a view, it was said, of giving opportunity for all possible objections to this proposed Social Security Act to be dealt with before the Bill should be drafted. This select committee again consisted of an overwhelming majority of members supporting the Government. As in the case of the previous investigation committee, it included no person of knowledge, experience or training in the matters which were the subject of the inquiry.

The Association sent representatives to appear before this select committee and submitted a prepared statement, a copy of which is enclosed. The select committee, having concluded its sitting, reported in a manner completely favourable to a Social Security Bill as had been outlined previously by the Prime Minister. A Bill was hurriedly drafted and, notwithstanding persistent and urgent requests from the Association to be permitted to discuss the Bill with the Government prior to its introduction, no such opportunity was afforded the profession.

Previously, assurances had been given that the fullest discussions would take place, but the Association was not permitted to know its actual contents or to effect any modifications before it was introduced to the House and published.

Upon introduction of the Bill, when it was seen for certain that it provided for a universal system, the profession with an unanimity of 95 per cent resolved to oppose the measure. The Bill had a speedy passage through parliament with only minor modifications in its text on account of the overwhelming majority held by the Government Party (56 out of 80 seats).

About a month following the passing of the Bill a general election was held, at which the Government retained its previous numerical majority with a considerable increase in the total number of votes cast in its favour. It was thus claimed that the people had completely endorsed the policy expressed in the Social Security Act.

The profession, up to the present time, has made no modification in its opposition to the introduction of the universal general practitioner system provided for in the Bill.

In recent weeks the Government has made overtures to re-open discussion, proposing to introduce a system of remuneration on a basis of payment-for-service-rendered. At the moment of writing these negotiations are still proceeding but to the profession as a whole these do not appear to open up much possibility of closer accord with the Government.

There are certain points of interest in regard to the position in New Zealand which are worthy of mention. So far as the profession is aware, there has been no great popular demand for Health Insurance. There are in existence a very great number of lodges and it is estimated that there are over 112,000 lodge members in New Zealand.

In most of these lodges provision is made for medical benefits mainly on a capitation basis, which covers a limited general practitioner service for the lodge member and his dependents. As far as city areas are concerned, medical attention for the indigent is available through the hospital boards, who will make available for applicants a medical practitioner for the district. The need for a better medical service was felt more by persons living in outlying districts and in certain isolated mining districts where the number of members belonging to medical clubs was not sufficient to provide adequate remuneration for a medical man.

For these reasons the profession thinks that on account of existing facilities and with the exception of the special cases mentioned above, there is less need for a system of Health Insurance in New Zealand than anywhere else in the world.

The medical profession, who alone are competent to advise on matters affecting medical practice, have not been consulted as fully as their position warrants. The profession has at all times indicated its willingness to co-operate with the Government on all matters affecting the health of the community. In other matters affecting health there has been a closer accord between the profession and the present Minister of Health, the Hon. Peter Fraser, than ever before. He has shown himself to have a good appreciation of matters affecting the medical profession and with the sole exception of this matter of Health Insurance very satisfactory relations exist between the profession and the Minister.

As far as the present Social Security Act is concerned, the features which are objectionable are outlined above. For those of low income the profession thinks that insufficient provision is made and that for this section of the community a service as complete as possible should be provided.

We think that the relief from all responsibility of payment for hospital services will greatly increase the applicants for admission to hospitals. It is estimated that at the present moment the hospital provision in New Zealand falls short of requirements by almost 1,000 beds. This condition will be considerably aggravated by the provisions in the Act.

An important part of the Act is its financial provision. There is to be levied on all earnings of the community a tax, to be called Social Security Tax, of 1/– in the £. This is to form the Social Security Fund and from this fund, aided as required by the consolidated fund, all payments in respect of various benefits provided for under the Act will be made. This includes, not only medical and hospital benefits, but also pensions, unemployment benefits, family benefits and even pensions for deserted wives.

From this Social Security Fund there is to be paid to Hospital Boards a sum which is estimated will be about £2 2s. 0d. per week towards the maintenance of patients in the public hospitals. This is something more than is now paid on the average by public hospital patients for whom the nominal maintenance fee is £4 4s. 0d. per week. It is to be noted that this amount of £2 2s. 0d. will be paid from the Social Security Fund in respect of patients who enter any approved private hospitals and can be applied in these institutions towards the cost of the patients' maintenance. In the case of public hospitals the payment from the Social Security Fund of £2 2s. 0d. per week is to be in complete settlement of the patient's account.

There is no doubt that the provisions of the Act will make a general practitioner service readily available to indigent persons.

In regard to remuneration, no discussions have taken place so far. It was suggested by the Chairman of the Government investigation committee that a capitation payment of £1 was contemplated. We think that, in view of the decision in Australia which fixed the capitation at 11/6 that some amount less than £1 will finally be decided upon. The profession, however, has resisted any discussions in regard to remuneration while the universal principle remains in the Act.

Further objections of the medical profession to the scheme are admirably set forth in a letter to the Committee of the House of Representatives on National Superannuation and Health Insurance. It is too long to quote in full but the following paragraphs are of particular interest.

"All are agreed that the promotion of health is a greater object than the treatment of sickness in that prevention is better than cure. We do not underestimate the importance of curative medicine, but National Health Insurance, which is really a system of indemnification for sickness, does not (especially in the proposals put forward by the Government) materially advance the greater object of the promotion of health. There are certain conditions in relation to environment, to conditions at work, to domestic help, to nutrition of the young, to preventive medicine and to research which we as a profession know to be unsatisfactory. These are referred to in some detail in our letter to the Hon. the Minister of Health in February, 1938. Continuous and studied attention to those conditions will do far more for the people than the introduction of any costly system of Health Insurance and the provision of a Universal General Practitioner service would do nothing towards remedying these deficiencies. Further, as we have previously pointed out on more than one occasion, there is pressing need for reform by proper coordination of all the health services in the community. This is specially apparent in hospital administration, the reform of which is long overdue and would remedy with very little extra cost to the ratepayers many of the defects in our present system. No doubt, the desire of the Government to introduce a system of Health Insurance into this country

is based on the observed beneficial results from this form of sickness indemnification in other countries. It is true that older countries have used the system in varied forms for many years mainly in order to mitigate the wage-loss due to sickness, and to make medical treatment available to the lower wage- and salary-earning sections of their industrial population. Social conditions not comparable with our own have made it difficult for the majority of these people to obtain from their own resources even minimal medical attention. It was on this account that the system was introduced, and while it has been successful in its own way, there is no justification for the claim that it is the best means of providing medical treatment or that it is a system that will contribute to any extent to an improvement in the health of the community.

"The position of this country is so different in respect of the nature and extent of the difficulties to be met that we venture to draw attention to certain points.

"(1) A country thinly populated and mainly devoted to primary production, as we are, has fortunately less of the type of population for whose assistance the system was devised. Furthermore, the scattered distribution of centres of population and the sparseness of settlement are features which are absent in those European countries which have adopted it.

"(2) During the half century which has passed since the health insurance system was first instituted in Germany our country has developed social service institutions, both statutory and voluntary, which have in large measure removed the difficulties which health insurance in other countries was devised to meet. This amelioration has been achieved on the one hand by the provision of pensions, health and hospital services and on the other by the growth of such voluntary organizations as Friendly Societies and the Plunket Society. For many years past it may be said with confidence that, as a result of our own development, a better type of medical attendance has been available in this country than in any now under the insurance system.

"For these reasons alone the need as it exists in this country does not affect so great a proportion of the population nor is it so pressing. Further, it differs in character in that with us the problem is not one so much affecting workers at centres of population as those remote from centres, and not so much the employed as those unemployed and past employment. Again, the difficulty of workers is not so much the obtaining of ordinary medical attention in their homes and at consulting rooms as the provision for major illness, home nursing, hospitalization, specialist treatment and laboratory and radiological investigation. These are the obstacles to complete medical service which we have sought to remove by the means suggested in the Plan we have previously submitted and as here briefly summarized: We think there should be provision of a *complete* medical and nursing service for those unable to make adequate provision for themselves. In this group we think there should be included not only necessitous persons but those whose income and family responsibilities are such as do not allow them individually to provide a full medical service for themselves and their dependents. For persons in better circumstances in which the chief burden is severe prolonged illness we propose the institution of an insurance scheme to provide cash benefits to cover, in part at least, the cost of hospital, specialist and consultant services. Our proposals imply the fixing of an income limit for beneficiaries. There can be no fundamental objection in the mind of the Government to imposing limits in respect of medical benefits for in its other proposals for social security all the other benefits are subject to a limit of this kind. In our view, if these measures are to be introduced gradually then the first objective should be the provision of a complete service for those for whom the need is greatest. We cannot see how those difficulties are in the least met by the provision of a free doctor and free medicine for everyone irrespective of their wishes or needs. The Prime Minister's proposals provide little for the people which is not available to them at the present time, and omit real impediments to efficient treatment. They suggest that the Government is more concerned with changing the present system than with improving the medical service of the people.

"To sum up we see in the projected Universal General Practitioner Scheme a mistaken method of approach to the problem of raising the standard of health of the community; no appreciable advantage in the treatment of disease over what we possess at present; unnecessary interference with and discouragement of individual initiative and enterprise; state domination over people's freedom and professional liberty; and deterioration of the standard of medical work."

HEALTH INSURANCE SCHEME OF THE NEW ZEALAND MEDICAL ASSOCIATION

In connection with the negotiations with the New Zealand Government the medical profession, in consultation with Sir Henry Brackenbury, prepared for the Government "A Plan for National Health Insurance." In this Plan the population was divided into four sections.

Section I. Old age pensioners, unemployed and unemployable, part-time and casual workers, etc. To this section complete medical service would be provided out of public funds.

Section II. Wage and salary earners whose total income does not exceed—

(*a*) 60/- per week gross, single.
(*b*) 80/- per week gross, married.

This section should be contributors for themselves and their dependents to a scheme whereby they would be provided with a complete health service as in Section I.

Section III. All having income not exceeding £500 per annum and not included in previous sections. This group should make their own arrangements for ordinary medical attendance but should contribute to a scheme for an Insurance Fund for hospital, specialist and consultant services.

Section IV. Those with income exceeding £500 per annum. This section is capable of providing all services for themselves but might, under certain

circumstances, avail themselves of the Insurance provided under Section III.

This scheme presented by the medical profession received very scant consideration from the Government.

SOUTH AFRICA

The Committee on Medical Economics in seeking information concerning the present status of Compulsory Health Insurance in South Africa was under the impression that a Health Insurance Act had already been produced by the South African Government. This was a misapprehension. No bill has been brought forward and any discussion concerning Compulsory Health Insurance has centred around the departmental report submitted to the Government in 1936 and known as the Collie Report.

The Committee on Medical Economics has been supplied with a copy of this report and with the letter from Dr. C. Louis Leipoldt, Medical Secretary of the South Africa Medical Association (British Medical Association) is herewith appended a short summary of the findings and recommendations of the South African Government departmental committee.

Capetown, 16th January, 1939.

Dr. Wallace Wilson,
Chairman,
Committee on Economics,
Canadian Medical Association,
203 Medical Dental Building,
Vancouver, B.C.

Dear Dr. Wilson,—

I was interested and glad to receive your letter of the 20th ultimo, for, as a matter of fact, I was on the point of writing to Dr. Routley to make enquiries about the development of your scheme of insurance. I am very glad indeed to have your excellent summary of the position, and I am taking the liberty—as there is no time to communicate with you to ask your permission—to publish it in the next issue of our Journal in which I pay some attention to the general question of invalidity insurance. I am sending you by this mail the published data about the position here. They will explain better, than I can find time to do in a short letter, what the present position is.

The answers to your questions *seriatim* are:—

1. The origins of the scheme—Were they political or social or both?

"The original movers in the scheme here were the doctors and not the lay men. That was perhaps owing to the fact that many of our doctors received their education in Germany and were much impressed by the 1866 scheme in Bavaria. I know that a doctor who had taken part in that scheme—the late Dr. L. Esselen, District Surgeon of Worcester—drew up a memorandum for the old Colonial Government of the Cape, urging the introduction of a scheme of invalidity insurance in this country."*

2. Was the profession consulted from the first in the drafting of the legislation?

"No legislation has been drafted yet. So far the medical profession has no cause to complain that it has been ignored."

3. What are the main features of the Act as to—
   (*a*) Classes of the population covered;
   (*b*) Scope of medical benefits;
   (*c*) Type and scale of remuneration;
   (*d*) Plan of administration;
   (*e*) Any other points of interest.

"Any legislation to be introduced will probably follow the lines of the Collie Report, the essentials of which were republished in our issue of 24th April, 1937, of which I forward you a copy."

4. Is the medical profession satisfied with the Act?

"The medical profession has not yet grasped the significence of this report, nor of any, and consequently it is not quite capable as yet of criticizing any draft legislation. Our Federal Council is trying to interest the Branches to actively consider the implications of the report."

5. What does the profession consider to be the good and bad features of the Act?

"Falls away."*

6. Did the profession at any time produce a plan of Health Insurance of its own and if so, of how much value was that scheme in the moulding of the present legislation?

"No! It has been suggested that the Association should do something of this nature, and I, myself, have strongly urged that we should give a practical lead. I revert to this subject in a leading article in this week's issue, of which I am sending you a copy.

"We are greatly interested, as you may well understand, in legislative developments on this subject in Canada and Australia. With us, too, the political influence of the Association is nil because hitherto it has entirely lacked organization and knowledgeable direction. We have four members of the profession in Parliament of whom two, Drs. Bremer and Gluckman, are thoroughly acquainted with state medical insurance and with the implications of the report and they may be looked upon as representing the progressive, forward view of the profession. The other two representatives have not made a study of the matter and carry much less weight.

"To the Collie report are attached two minority reports which were produced unfortunately by our own representatives on the commission, who held views which the majority of the members do not share. I do not think these minority reports will be taken into consideration, or that they will have any influence whatever on draft legislation, if such is introduced. With regard to such legislation I am credibly informed that a draft bill has been prepared but not yet considered by the Cabinet, and that it follows in all essentials the English Act with such modifications as

* In a later communication Dr. Leipoldt says—"individual doctors and not the profession as a whole brought forward the suggestion. The profession as a whole was only organized in 1926 when our Association was formed."

* "What I meant by 'falls away' was that it has not been necessary for us to consider details although we are discussing the recommendations of the Commission at our meetings. The present Government is unlikely to move in the matter for some time."

the Collie report suggests. I think this is only the skeleton compiled by the Law Advisers on Cabinet instruction, and it has certainly not been compiled with the assistance of the Chairman of the Commission or anybody who is familiar with the practical working of such legislation. That was the case too with our Workmen's Compensation Act which was afterwards entirely redrafted in consultation with medical and trade experts.

With kind regards and all good wishes,''

I remain,

Yours sincerely,

C. Louis Leipoldt,

Medical Secretary.

The Collie Report

At the commencement of its work the Departmental Committee sent out questionnaires to a great number of organizations, public bodies, and individuals. Commenting on the comparatively few answers received the Committee remarked—

''If but little interest was taken, this is understandable to some extent. The subject of Health Insurance is a difficult and complicated one, and comparatively few people in this country have any knowledge of it.''

An analysis of the replies is then given and the Committee proceeds to a study of the problem of providing Health Insurance in sparsely-populated countries. In this section the following interesting statement occurs:

''The South African delegates of the International Labour Conference held at Geneva in 1927 were instrumental, along with the Spanish delegates, in inducing the International Labour Office 'to undertake an inquiry and to publish as complete a report as possible upon the most effective methods of overcoming the obstacles which hinder the organization of a system of compulsory sickness insurance in countries which are sparsely populated or where geographical conditions render communication difficult.' The International Labour Office proceeded with the inquiry, but we were advised in January of this year that no report on the result of the inquiry has been issued by the Office owing to the small number of replies received from the countries to which its inquiries were addressed, amongst them being the Union of South Africa.

''In 1931 the Health Organization of the League of Nations convened a conference of representatives of European States for the purpose of a technical international study of rural hygiene. The report, in two volumes, was published before the end of the year; it enunciates some useful general principles and makes recommendations for ensuring medical assistance, for organizing public health medical services, and for the sanitation of rural districts, but it makes no contribution to the solution of the problem of health insurance for the people living in thinly-populated areas. Doubtless, however, the inquiries of the Labour Office and the Conference of 1931 may have stimulated consideration and activity in the countries concerned of the problem of how to bring medical assistance and advice to the sparsely-populated areas, and during recent years some progress has been made towards instituting schemes of health insurance and for a more adequate medical service in some of the countries concerned.''

The Problem of Sparsely-Populated Countries

The report then reviews the present status of Compulsory Health Insurance in countries with sparsely-populated areas such as Australia, New Zealand, Chile, United States of America and Canada, and in connection with Canada has this to say:

''The medical profession in Canada, it may be added, also appears to be very much alive to the question of Health Insurance, both as it affects its members and the community generally. We have read with much interest a report of the Committee on Economics of the Canadian Medical Association, dealing with a plan for Health Insurance in Canada. The only benefit to be provided under the plan is the medical benefit and it is stated in the report that 'the cash benefit is the cause of most of the difficulties associated with Health Insurance. It brings in the question of certification, it drains the fund financially and, all told, makes administration and finance unduly difficult'.''

The following are taken from the closing paragraphs of this section:

''There is no doubt in our minds that the problem of providing Health Insurance in sparsely-populated countries such as South Africa, is not only very different from the problem which has been so successfully solved in more densely-populated countries, but is of such a difficult nature that no satisfactory solution which could be applied generally to all countries with similar conditions has yet been found by the Government of any sparsely-populated country.

''It seems to us that, although each country may benefit from the investigations made and experience gained by other countries, it will be necessary for each to solve its problems on the lines which experiment and experience show to be the most suitable for itself.''

State Medicine

The next section of the report is a detailed analysis of the case for and against a State Medical Service. It agrees that the time is not yet ripe for a State Medical Service in South Africa but it also agrees with the International Labour Office in its summing-up of the present position as affecting the states adhering to the League of Nations, as follows:—

''Public Health experts are exerting a slow but steady pressure for a widening of the sphere of public health services, which in their view should not be confined to the enforcement of sanitary regulations and collective measures for the prevention of disease, but should extend to the organization of individual medical assistance, both preventive and curative, at least for social diseases.

"The federations of social insurance funds, which represent organized groups of insured persons, and often of employers as well, are asking, in almost every country, for the creation or maintenance of compulsory social insurance schemes to protect wage earners and their families against occupational and social risks: they claim that the insurance institutions should have administrative and financial autonomy, and that the representatives of the parties concerned should have a share in their administration.

"The medical associations are putting up a vigorous and sometimes vehement defence of the free exercise of their profession, and are resisting, often successfully, a process which they regard as the subordination of medicine to the State, with a resulting 'officialization' of their profession. But it must be admitted that this resistance grows daily harder to maintain, owing to the universal and increasing over-crowding in the medical profession, at any rate in the cities, combined with the reluctance of liberal principles to proposing or taking any effective measures to remedy this state of affairs.

"What will be the result of the interplay of these forces, with their divergent, and in some cases mutually exclusive aims? It would be difficult enough to predict the outcome, even if the future of public health services and social insurance institutions depended solely on the views and interests of the medical profession, the public health experts, and the employers' and workers' organizations. But it is obvious that public services and social institutions are subject to the influence of every change that may occur in the political system, economic life and social structure of the country concerned.

"The introduction of a socialist system, implying the nationalization of the means of production and exchange and the abolition of the distinction between employer and employed, would mean the disappearance of the liberal professions and the establishment of vast public medical and health services.

"Systems based on the corporative principle, which are now being discussed in various countries, tend to affirm the supremacy of the State as a reaction against an individualism which they regard as excessive, and is bound to lead to conflicts between persons or groups—conflicts for which liberalism has no solution to offer, despite the harm they do to the true interests of every national community. Any corporative system—by definition authoritative and anti-liberal—would undoubtedly make profound changes in the status of the medical profession and regulate the relations between it and the institutions for insurance, public health, and relief by means of collective agreements with binding force.

"Under the liberal-capitalist system which is at present dominant in most countries, social history for many years past has been marked by a steady extension of social services run by the State or under its direct control. Despite resistance and protest, State intervention has constantly and rapidly enlarged its scope, aided first by the war, then by the economic depression, and all the evidence points to a continuation of this process. The whole tendency of economic planning, as applied to the subject under discussion, is towards the establishment of public medical institutions, instruments of a coordinated sanitary policy. It is fairly safe to say that in the near future, under combined influence of more extensive public health services and strong social insurance, the provision of medical assistance, both individual and collective, both curative and preventive, will become an organized service for an increasing proportion of the population of every country."

MEDICAL BENEFITS

After a long and detailed discussion of the provision of the various kinds of medical benefits under the two headings Urban and Rural, the Committee proceeds to recommend medical, funeral and sickness benefits for urban areas while "we are reluctantly compelled to arrive at the conclusion that the time is not ripe for the initiation of a scheme of Health Insurance for our rural areas."

THE SCHEME FOR URBAN AREAS

The broad details as particularly of concern to the medical profession are well digested from the Collie Report by Dr. C. J. Albertyn in the *South African Medical Journal*, March 11th, 1939, and your Committee could not do better than quote his summary as follows:—

"The scheme suggested by the Committee will be compulsory and apply to all employees with an income not exceeding £400 per annum. Those insured are classed into eight groups according to their income (*a*) under £36; (*b*) £37 to £60; (*c*) £61 to £90; (*d*) £91 to £120; (*e*) £121 to £180; (*f*) £181 to £240; (*g*) £241 to £320; (*h*) £321 to £400.

"Weekly contributions will be paid by or on behalf of each of these groups, ranging from 1s. to 5s. 6d. per week. Except in the lowest group the insured, the employer and the Government take part in the contributions.

"It is suggested that the medical profession be paid an annual capitation fee of 9s. for all insured earning up to £180 p.a., and 13s. for those with an income over £180. It is proposed that the cost of specialist treatment shall be met by a quarter of the above amounts.

"The amount recommended as capitation fee is in accordance with the recommendation of the Federal Council, and one may take it, is to the satisfaction of the profession. Benefit will consist of ordinary service, drugs, hospital service, specialist service, funeral benefit, maternity benefit and sick pay. Of these benefits the first five will go into operation the moment a person has paid his first instalment; the other two will only be of effect after he/she has been in insurance at least twenty-six weeks. A special formula is laid down which will operate to determine when these will come into force when an insured has been out of insurance for some time.

"*Medical Benefit* is to be available to all insured persons, for the dependent wives of insured men, for the incapacitated husbands of insured women, and for the dependent children under the age of 16 of insured men and women.

"*Ordinary Medical Benefit* shall include treatment by a general practitioner, attendance by a general practi-

tioner during the pregnancy of an insured woman or the dependent wife of an insured man, but not for the confinement or for any illness arising therefrom during the subsequent four weeks, and the supply of drugs and medicines, together with curative appliances according to a list to be laid down by regulation.

"*Specialist Benefit* shall include all medical and surgical treatment not falling under ordinary medical treatment, the division between the two classes of medical benefit to be in accordance with regulations to be drafted after consultation with the medical profession. This benefit will include any treatment for which a specialist is called in at a confinement or for any illness arising therefrom, but will, of course, exclude the corresponding general practitioner treatment.

"*Hospital Benefit* shall consist of the payment of 9s. per day for a period not exceeding 13 weeks in respect of any illness, under wage-groups (*f*) to (*h*), where a person, at the request of his doctor, is admitted to a hospital or approved nursing home, or where, lacking accommodation in such hospital or home or for some adequate reason, a qualified nurse is in full attendance in the person's home at the doctor's request.

"No hospital provision has been made for groups (*a*) to (*e*) earning up to £180, since the insured in these groups generally receive free treatment in hospital. No hospital benefit will be payable under certain circumstances, *inter alia*, when detention in hospital has been of shorter duration than two consecutive days, or the illness is the result of an accident covered by the Workmen's Compensation Act.

"*Maternity Benefit* will consist of a lump payment to the insured of from £2 to £9 according to the wage-group.

"Confinement pay for four weeks will be paid in the case of an insured woman if she is not at work during that time.

"*Funeral Benefit* shall be payable at the death of an insured or of the dependent wife of an insured man or of the incapacitated husband of an insured woman or of the dependent child under the age of 16 of an insured man or woman, provided that only one benefit shall be payable on each death. The amount varies from £4 to £11 according to the wage-group.

"*Sickness Benefit*: Sickness is defined to be inability to do his ordinary work by reason of the abnormal state of an insured's health, provided the insured complies with the doctor's orders or other instructions relating to his conduct while ill. The amount of sick pay for the first twenty-six weeks will be from 4s. to 32s. per week for the insured, plus a quarter of that amount for a dependent wife or incapacitated husband and an eighth for a dependent child.

"The amount of sick-pay will be reduced by one-half after twenty-six weeks and for the subsequent fifty-two weeks. No sick-pay will be granted for the first three days of sickness. The sickness week will consist of six days.

"*Administration*: The administration of the scheme will be borne by a Board of Management composed of representatives of the Government, the insured persons and the employers."

It is recommended that one of the representatives of the Government should be a member of the medical profession.

The following table shows how the funds to finance this scheme are to be raised:

Wage Group	*Weekly Contribution*							
	Total		*Of which payable by*					
			Government		*Employer*		*Insured*	
	s.	d.	s.	d.	s.	d.	s.	d.
(*a*)	1	0	0	3	0	9	—	—
(*b*)	1	5	0	6	0	9	0	2
(*c*)	1	10	0	6	1	0	0	4
(*d*)	2	5	0	6	1	2	0	9
(*e*)	3	0	0	4	1	5	1	3
(*f*)	3	10	0	4	1	9	1	9
(*g*)	4	8	0	4	2	2	2	2
(*h*)	5	6	0	4	2	7	2	7

UNITED STATES OF AMERICA

Because of much appearing in the lay press there has been a great deal of confusion of thought as to what actually is transpiring in medical economics in the United States.

Dr. R. G. Leland, head of the Bureau of Economics of the American Medical Association, has been good enough to forward to your Committee a short summary of the general trend of medical economics in our great neighbour to the south.

It was found impossible in the space allotted to digest the large amount of material made available through Dr. Leland's kindness, but much of it is accessible to members of Council through the columns of the *Journal of the American Medical Association*.

We commend a study of this information to all those interested in watching Medicine in the United States as it passes through a great transition stage on the road to—what?

AMERICAN MEDICAL ASSOCIATION

535 North Dearborn Street,
Chicago, April 17, 1939.

Dr. Wallace Wilson, Chairman,
Committee on Economics,
Canadian Medical Association,
203 Medical Dental Building,
Vancouver, B.C.

Dear Doctor Wilson:

The press of work in connection with the proposed hearings on the National Health Program and the Wagner Bill as well as preparation for the annual session of the American Medical Association has prevented my writing as complete a résumé of trends in medical economics as I would like.

However, while the accompanying memorandum is brief, it, together with the material sent to you under separate cover, gives a fair appraisal of the trend of medical economics.

TRENDS IN MEDICAL ECONOMICS

Following is a brief résumé of some of the major trends in medical economics in the United States.

1. Of first importance are the developments which point to the likelihood that government, either state or federal, will enter the field of curative medical service. The outstanding indication of this tendency is the proposal looking toward a National Health Program as developed by the Interdepartmental Committee to Coordinate Health and Welfare Activities which was appointed by President Roosevelt. This committee appointed a Technical Committee on Medical Care which prepared a report entitled "The Need for a National Health Program." The United States Public Health Service also has just completed a special survey entitled "The National Health Survey" which purported to collect extensive information concerning the health status of the nation. Based largely on these two sources, the completed text of the National Health Program was presented by the Interdepartmental Committee to a National Health Conference which met in Washington last July. This program, proposing to expand greatly the public health and maternal and child health services, to increase hospital facilities, to extend medical care for the medically indigent, to introduce a program for compulsory sickness insurance or public medical care and to inaugurate a system of disability insurance for loss of wages during sickness, was prepared by five members of governmental agencies and with but little assistance from the medical or allied professions (See The National Health Conference, *J. Am. M. Ass.*, **111:** 426 (July 30), 1938 for a full report of the National Health Program).

In view of the importance of such a far-reaching program, the House of Delegates of the American Medical Association was called in special session to consider the proposals offered in the National Health Program. After careful analysis of the proposals (See House of Delegates Considers National Health Program, *J. Am. M. Ass.*, **111:** 1188 (Sept. 24) 1938, especially the report of the Reference Committee on pp. 1215-1217 which is also given in the reprint entitled American Medical Association Action on Proposals of the National Health Conference. See also the Mimeographed article "The Significance of the National Health Program") the American Medical Association, while approving of most of the general objectives of the National Health Program, pointed out the necessity for more reliable basic information in all of the proposals—for example, the inaccurate conception concerning the need for hospital construction and the undesirability of expanding the activities of public health departments into treatment of disease.

The proposals involved in the National Health Program were also carefully analyzed by professional groups such as the American Dental Association, the American Hospital Association, the Catholic Hospital Association, the Protestant Hospital Association, the American Public Welfare Association and the American Public Health Association. The recommendations of these groups coincide in practically all respects with the recommendations of the American Medical Association concerning the National Health Program.

One of the suggestions of the American Medical Association was that a committee be appointed to confer with federal representatives relative to the National Health Program. A committee appointed by the House of Delegates and committees appointed by the other professional groups endeavoured to meet with the Interdepartmental Committee to Coordinate Health and Welfare Activities concerning the proposals in the National Health Program. While a number of such conferences were held between June, 1938 and January, 1939, the National Health Program was transmitted to the President with scarcely a single change in the program as originally drafted. The President in turn has submitted the Program to the Congress of the United States (House of Representatives Document number 120).

Subsequently a bill was introduced by Senator Wagner to begin fulfillment of the proposals of the National Health Program. (See The Wagner Bill for Medical Care, reprint from *J. Am. M. Ass.*, **112:** 997 (March 11) 1939 which gives an analysis of this bill.) This bill has been referred to the Senate Committee on Education and Labour.

The present stage of this trend is that public hearings will be held concerning the proposals for enacting the National Health Program into federal legislation. At the same time, consideration will also be given to other expansions of the Social Security legislation which today embodies provisions concerning public health and maternal and child health services.

2. A second trend of major importance involves the development of new methods for the distribution of medical services. In the forefront of this movement are the state and county medical societies which have developed a variety of plans to organize payments for the distribution of medical services. A number of other agencies are also developing medical service plans, notably hospitals, nonprofit corporations, insurance companies, voluntary associations and individual promoters. (For a fairly complete discussion of these various medical service plans, see the mimeographed set of material entitled "Medical Service Plans," which includes digests of types of plans now being considered by medical societies. See also Proceedings of the Special Session, *J. Am. M. Ass.*, **111:** 1208 (Sept. 24) 1938, and Trends in the Distribution of Medical Care, *J. Am. M. Ass.*, **112:** 1528 (April 15) 1938. A report "Organized Payments for Medical Services" which will be published within the next few weeks contains descriptions of practically all types of medical care plans. (We shall send you a copy of this report as soon as it is published.)

The development of new arrangements for the distribution of medical services involves many related problems. Perhaps the most important of these is the tendency to legalize the corporate practice of medicine which tends to place an association or corporation in control of the distribution of medical services, relegating the physician to the position of an employee. It has been generally recognized as contrary to good public policy for corporations to attempt to practise a profession inasmuch as it is virtually impossible to hold a corporation responsible for maintenance of standards of practice. The courts of the United States have generally held that the corporate practice of a profession is undesirable and that the public will be served better if indi-

vidual practitioners are held fully responsible for the practice of a profession.

The introduction of a third party agency between the patient and physician has caused the medical profession much concern. The medical profession of the United States has never opposed the insurance principle as a method of paying medical bills but is opposed to a misapplication of the insurance principle which results in placing a third party agency or corporation in control of the relations between a physician and his patients. The medical profession suggested that the insurance principle can best be applied if it is restricted solely to the *payment* of medical bills by returning to the insured a specified cash benefit for the services covered by the insurance. (See the mimeographed outline "The Attitude of the American Medical Association Toward Group Hospitalization Plans.")

The indications are that legislation will be passed to permit nonprofit corporations to conduct group payment or medical insurance without being held to the strict requirements of the insurance law. In several states the medical societies are seeking the passage of legislation which will authorize nonprofit corporations to undertake medical expense indemnity insurance plans without being held to deposit the large sums of money required under the insurance laws. Whether the arrangements will be of the cash indemnity type which seems to be gaining favour or of the medical service type such as the medical service bureaus in the states of Washington and Oregon is as yet uncertain. In either event, it appears that the successful operation of a group payment or medical insurance plan will call for the full cooperation of medical societies. The history of individually promoted or restricted group contract practice arrangements gives strong evidence that a medical service plan must give free choice of physician and receive the full cooperation of participating physicians if it is to be operated satisfactorily.

3. Concerning other trends in the field of medical economics, the enclosed Annual Reports of the Bureau of Medical Economics contain discussions of many of the more important developments. (See *J. Am. M. Ass.* **110:** 1470-1476 (April 30) 1938, and *J. Am. M. Ass.* **112:** 1367-1374 (April 8) 1939). Undoubtedly the Proceedings of the Annual Session of the American Medical Association to be held in St. Louis May 15th to 19th will point out the plans of the medical profession for the future.

R. G. Leland, M.D., Director,
Bureau of Medical Economics.

All of which is respectfully submitted.

WALLACE WILSON,
Chairman.

Approved.

The following Supplementary Report was presented by the Chairman of the Executive Committee:—

"Acting upon the invitation of the Executive Committee, Dr. Wallace Wilson appeared before the Committee last March and presented an interim report dealing with the subject under his purview. At the conclusion of this report, Dr. Wilson offered several recommendations. These recommendations were dealt with by the Executive and a Sub-Committee was appointed to consider them further and report to this meeting. The Sub-Committee recommended that Mr. Hugh Wolfenden, Consulting Actuary and Statistician, be retained to act in an advisory capacity in medical economics. The Executive Committee approved of this recommendation and instructed that Mr. Wolfenden be invited to attend this session of General Council in order that he may be in a better position to assist us in whatever steps we take growing out of this meeting. The Executive Committee recommended that Mr. Wolfenden be engaged as from July 1, 1939, for a period of one year, at a salary of $1,000, to assist the C.M.A. in any way in his power in its study of the question of medical economics."

This supplementary report was approved.

In speaking to this report, Dr. Wilson pointed out that it is the feeling of the Committee on Economics that a program of education should be carried out by means of articles appearing regularly in the *Journal*, and papers on medical economics at annual meetings of the C.M.A. and also of the Divisions and Branches. The Committee also recommended that the C.M.A. proceed to make a study of the broad question of medical services in Canada. In all of this program Mr. Wolfenden will act as assistant and advisor. Dr. Wilson stated that, in the opinion of his Committee, any plan of health insurance for the people of Canada should come as a result of joint work on the part of the Government and the C.M.A.; that, if and when the time comes when compulsory health insurance enters the field of politics, the C.M.A. should be ready and should seek permission from the Government to sit in and cooperate in developing a plan that would meet the needs of the country.

The Chairman called upon Mr. Wolfenden to speak to Council. Mr. Wolfenden stated that there is a vast misunderstanding of what health insurance is, what it can do and cannot do. He stressed the importance of education, both of the medical profession and the public —education in fundamental principles; and stated that it would be his desire to study the matter, and weigh the advantages and disadvantages in the balance both in respect to the medical profession and also to the country as a whole; and that it would be in the spirit of a fact-finding investigator that he would undertake this work.

Dr. J. A. Hannah of Toronto explained the plan of voluntary health insurance now in operation by Associated Medical Services Incorporated.

The following resolution was finally passed:

THAT WHEREAS the special committee of the Executive Committee appointed to deal with the matter of Medical Economics has reported upon arrangements proposed to be entered into with Mr. Hugh Wolfenden;

AND WHEREAS Mr. Wolfenden has accepted the terms and conditions laid down in the special committee's report, the arrangements be now considered completed, to take effect on July 1, 1939; and that Mr. Wolfenden's services be placed at the disposal of and under the direction of the Committee on Economics.

REPORT OF THE COMMITTEE ON LEGISLATION

Mr. Chairman and Members of General Council:—

In so far as the House of Commons is concerned there is very little to report on legislation affecting the medical profession.

Up to date, during the present session, there has taken place the perennial discussion on State Medicine and allied subjects,—Health Insurance, Periodic Health Examinations, etc. Each year the discussion shows a growing trend of thought favouring some form of National Health Insurance. The Minister of Pensions and National Health, the Honourable C. G. Power, closed the debate by pointing out that the country is not in a financial position to adopt any scheme of Health Insurance at the present time, even if the constitutional obstacles with regard to provincial rights were overcome.

Bill 13, An Act to Amend the Food and Drugs Act was introduced and passed with certain modifications, some of which were suggested by this Committee after consultation with the Committee on Pharmacy. The co-operation of this latter Committee is hereby acknowledged with thanks.

Another Bill is to be introduced in the Senate respecting certain amendments which the Royal College of Physicians and Surgeons of Canada desires to its Federal Charter. This Bill will receive the support of all members of the profession who sit in the House of Commons and the Senate.

Your Committee has approached various departments of the Federal Government on the following subjects at the request of your Executive Committee:—

(1) The desirability of having a representative of the Canadian Medical Association on the Dominion Council of Health.

(2) Income Tax abatements for members of the medical profession similar to those accorded by the U.S.A. Government, permitting deductions for travelling expenses, including amounts paid for transportation, meals and lodging, necessarily incurred in professional visits to patients *and in attending medical meetings for a professional purpose.*

(3) Fraudulent cures for deafness which are being advertised in Canada, namely, "Aurine Ear Balm", and "A. O. Leonard's Invisible Ear Drum".

The Province of Quebec section of this Committee reports that Bill No. 109 of the Quebec Legislature, introduced by Chiropractors to legalize their association in the Province of Quebec was rejected by the Public Bills Committee.

All of which is respectfully submitted.

C. J. VENIOT,
Chairman.

Approved.

JOINT COMMITTEE FOR THE DISCUSSION OF MUTUAL PROBLEMS

During the past few years, it has been evident that there are many matters of common concern and interest to various groups in the fields of medical practice, medical education, medical licensure and hospital care. At the present time we lack adequate facilities for bringing these various groups together. The impression has been formed that a joint committee should be established which would provide an avenue whereby problems or subjects of concern to two or more of the groups represented could be studied and, perhaps, satisfactorily solved. The following organizations were approached:

The Medical Council of Canada.

The Provincial licensing bodies.

The medical colleges in Canada.

The Canadian Hospital Council.

The Royal College of Physicians and Surgeons of Canada.

The provincial medical associations.

The Canadian Medical Association.

As a result of the correspondence with the above mentioned organizations a meeting was held in Montreal, attended by representatives of the different groups. Among those present were representatives of eight Provincial Licensing Organizations, nine Medical Colleges, the Canadian Hospital Council, Royal College of Physicians and Surgeons of Canada, six of the Provincial Medical Associations, the Canadian Public Health Association and the Registrar of the Medical Board from Newfoundland. This group discussed the advisability of having a committee appointed to consider over-lapping and borderline problems that arise; and a motion was passed to the effect that a similar conference be held annually to consider problems common to two or more bodies. It was decided that an organization committee be set up under the Chairmanship of Dr. F. J. H. Campbell, with power to name the other members of the Committee.

OFFICERS

The following are the officers of the Association for the ensuing year:

President—Dr. Frank S. Patch, Montreal.

President-Elect—Dr. Duncan Graham, Toronto.

Chairman of General Council and of the Executive Committee—Dr. T. H. Leggett, Ottawa.

Honorary Treasurer and Managing Editor—Dr. Sclater Lewis, Montreal.

General Secretary—Dr. T. C. Routley, Toronto.

Associate Secretary—Dr. Harvey Agnew, Toronto.

Editor—Dr. A. G. Nicholls, Montreal.

PROVINCIAL REPRESENTATIVES ON THE EXECUTIVE COMMITTEE

British Columbia—Dr. G. F. Strong, Vancouver.

Alberta—Dr. A. E. Archer, Lamont.

Saskatchewan—Dr. A. W. Argue, Grenfell.

Manitoba—Dr. O. C. Trainor, Winnipeg.

Ontario—Dr. J. C. Gillie, Fort William;
Dr. Harris McPhedran, Toronto;
Dr. G. Stewart Cameron, Peterborough.

Quebec—Dr. Léon Gérin-Lajoie, Montreal;
Dr. W. W. Lynch, Sherbrooke;
Dr. A. W. Young, Montreal.

Nova Scotia—Dr. J. R. Corston, Halifax.

New Brunswick—Dr. W. E. Gray, Milltown.

Prince Edward Island—Dr. W. J. P. MacMillan, Charlottetown.

CHAIRMEN OF COMMITTEES

Personal Archives—Dr. C. F. Wylde, Montreal.

Awards, Lectures and Scholarships—Dr. Duncan Graham, Toronto.

Department of Cancer Control—Dr. T. C. Routley, Toronto.

Study Committee on Cancer—Dr. J. S. McEachern, Calgary.

Central Program Committee—To be appointed.

Ceremony—Dr. A. T. Bazin, Montreal.

Constitution and By-Laws—Dr. R. I. Harris, Toronto.

Advisory Committee to Department of Hospital Service—Dr. S. R. D. Hewitt, Saint John.

Advisory Committee to the Department of National Defence—

British Columbia—Dr. G. E. Gillies, Vancouver; Dr. Thomas McPherson, Esquimalt.

Alberta—Dr. A. C. Rankin, Edmonton; Dr. Geo. R. Johnson, Calgary.

Saskatchewan—Dr. T. M. Leask, Moose Jaw; Dr. E. A. McCusker, Regina.

Manitoba—Dr. F. A. Young, Winnipeg; Dr. J. A. Gunn, Winnipeg.

Ontario—Dr. C. P. Fenwick, Toronto; Dr. J. E. Davey, Hamilton; Dr. W. R. Jaffrey, Hamilton; Dr. F. Etherington, Kingston; Dr. Geo. A. Ramsay, London; Dr. Geo. Hooper, Ottawa.

Quebec—Dr. A. T. Bazin, Montreal; Dr. J. U. Gariepy, Montreal; Dr. W. H. Delaney, Quebec; Dr. Jos. Vaillancourt, Quebec.

New Brunswick—Dr. D. C. Malcolm, Saint John; Dr. A. S. Kirkland, Saint John.

Nova Scotia—Dr. K. A. MacKenzie, Halifax.

Prince Edward Island—Dr. J. A. MacPhee, Summerside.

Economics—Dr. Wallace Wilson, Vancouver.

Credentials and Ethics—Dr. Ross Mitchell, Winnipeg.

Advisory Committee on Finance—

Dr. D. Sclater Lewis (*Chairman*);
Dr. A. T. Bazin;
Dr. C. F. Martin;
Dr. F. S. Patch.

Hospital Internships—Dr. Alfred Haywood, Vancouver.

Laboratory Technicians—Dr. W. J. Deadman, Hamilton.

Legislation—Dr. C. J. Veniot, M.P., Bathurst.

Maternal Welfare—Dr. J. D. McQueen, Winnipeg.

Medical Education—Dr. F. J. H. Campbell, London.

Meyers Memorial—Dr. J. T. Fotheringham, Toronto.

Nutrition—Dr. F. F. Tisdall, Toronto.

Osler Memorial—Dr. Duncan Graham, Toronto.

Pharmacy—Dr. V. E. Henderson, Toronto.

Post-graduate—Dr. Duncan Graham, Toronto.

Public Health—Dr. F. W. Jackson, Winnipeg.

HONORARY MEMBERSHIP

Honorary Membership was conferred upon Dr. E. P. Cathcart, of Glasgow, Scotland, and Dr. A. O. Whipple, of New York City.

CONCLUSION

In addition to the foregoing, consideration was given to a great many other details in connection with the work of the Association, which were passed to the various committees for study and report.

All of which, on behalf of the General Council of the Canadian Medical Association, is respectfully submitted.

T. C. ROUTLEY, *General Secretary.*

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The Canadian Medical Association Journal

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AND ITS AFFILIATED PROVINCIAL MEDICAL ASSOCIATIONS

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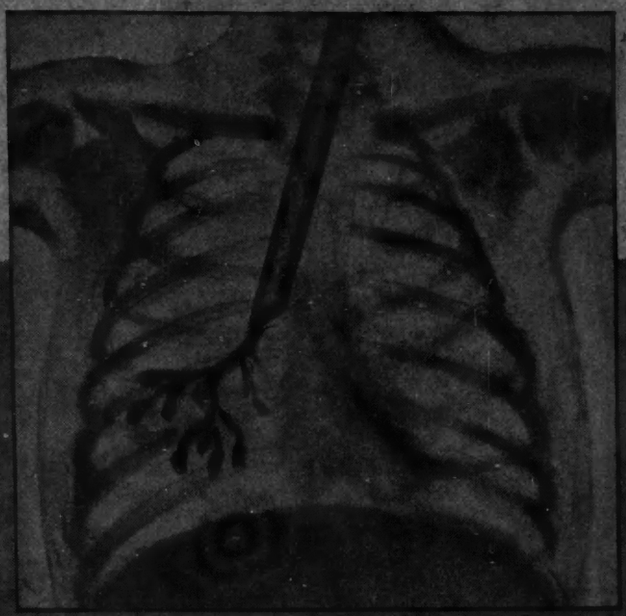

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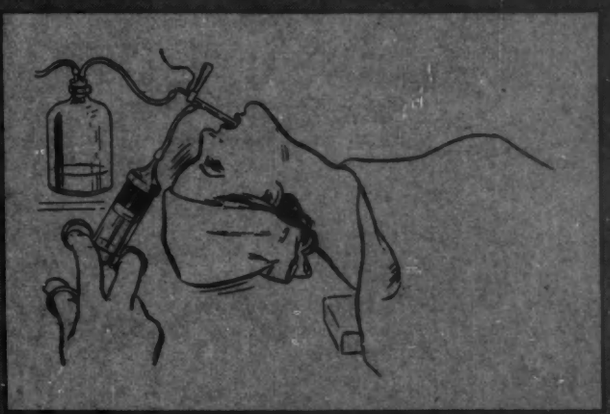

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* Jackson, Chevalier; Bronchoscopy and Esophagoscopy, Saunders, 1927; p. 304.

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